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OFFICIAL REPORT

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The following abbreviations are used to show a Member's party affiliation:

Abbreviation	Party/Group
CB	Cross Bench
Con	Conservative
DUP	Democratic Unionist Party
GP	Green Party
Ind Lab	Independent Labour
Ind SD	Independent Social Democrat
Ind UU	Independent Ulster Unionist
Lab	Labour
Lab Co-op	Labour and Co-operative Party
LD	Liberal Democrat
Non-afl	Non-affiliated
PC	Plaid Cymru
UKIP	UK Independence Party
UUP	Ulster Unionist Party

No party affiliation is given for Members serving the House in a formal capacity or for the Lords spiritual.

House of Lords

Tuesday 18 January 2022

11 am

Prayers—read by the Lord Bishop of Birmingham.

Health and Care Bill

Committee (3rd Day)

11.05 am

Relevant documents: 15th and 16th Reports from the Delegated Powers Committee, 9th Report from the Constitution Committee

Clause 10: Funding for service integration

Amendment 20

Moved by ***Baroness Meacher***

20: Clause 10, page 6, line 19, at end insert "including how it must be used to support service integration for children"

Member's explanatory statement

This amendment would clarify and prioritise how use of sums paid to NHS England under section 223B of the National Health Service Act 2006, better known as the Better Care Fund, can be used towards service integration for children.

Baroness Meacher (CB): My Lords, I will also speak to Amendment 177. Amendment 20 requires the Secretary of State to ensure that the better care fund, an important and successful initiative, is used to support service integration for children as well as adults. As the Bill stands, the better care fund will continue to be focused exclusively on adults. This is one of a number of amendments that we will debate over the coming weeks which together ensure the children are given equal treatment with adults in the Bill. I assume at the outset that the Minister agrees in principle with us that children and adults should be treated equally in the Bill. Can he give the House an assurance that this is the case—I cannot believe it is not—and if it is not, can he give us the reasons why?

We understand that the fund has focused on adults until now but surely it is time to extend it to children's services. When the better care fund is all about integration of health and social care, it is hard to understand why children's services should be excluded. Integrated multiagency support for children and families is key to delivering on the Government's policy agenda, including for disabled children, those with special educational needs, children supported by the social care system and children during the first 1,000 days of life. Extending the scope of the better care fund to children would greatly accelerate this process of integration and support the Government's ambitions for children.

I recognise that the funding streams and systems involved in services for children are complicated and it would involve work to extend the better care fund to incorporate those systems. However, this complexity is precisely why good and integrated services for children are so hard to achieve and why the better care fund could be so beneficial.

To illustrate the point, I will quote from a letter I received last week from Julian Wooster, the Somerset director of children's services. He welcomes this amendment and explains that

"unfortunately we currently have a perfect storm of issues nationally in relation to placements of teenagers with complex needs, which is having a detrimental impact on their well-being."

Apparently, the Association of Directors of Children's Services has made a number of submissions, including the following commentary to the review of children's social care which is under way:

"Despite long standing and ongoing discussions about the needs of children across the children's social care, mental health and youth custody secure estate, the three systems continue to be separately commissioned, operate under separate legislative frameworks and are the responsibility of different government departments, each with different priorities. This can present practical barriers to local innovations and change. Locally in Somerset the council and NHS colleagues have worked well together on a joint initiative, which is receiving national interest. If the country is to benefit, Wooster claims, there needs to be a joint framework which the better care fund could provide."

I am aware that officials from the department have been having positive conversations with colleagues from the Children and Young People's Health Policy Influencing Group and the National Children's Bureau, and I hope these will continue. But what I hope today is that the Minister will clarify to the House is that he has no objections to the principle of extending the remit of the better care fund to children, and that he is happy to explore how that might be achieved.

I turn briefly to Amendment 177, which seeks to ensure that the needs of those aged nought to 25 are adequately met under the integrated care systems. The amendment would require the Secretary of State to publish guidance on how ICSs should meet their obligations and with which ICS bodies would be required—that is a very important word—to comply. I do not think that I really need to persuade the Government that meeting the health needs of children from birth to adulthood is perhaps the most important investment in the health of the nation. Obviously, good health in childhood is likely to lead to good health in adulthood, to the benefit of every single one of us and to our NHS and taxpayers. We know that integrated care systems will have to cater for all ages in the context of the historically large backlog of appointments and treatments. It will be all too easy for particular groups to be left behind, unless there are specific provisions in the legislation to make sure that they are not.

As this Bill passed through the House of Commons, I was really pleased to hear that the Minister for Health had recognised the importance of meeting the needs of babies, children and young people. In particular, I warmly welcomed his commitment in Committee to ask his officials to develop bespoke guidance spelling out how ICSs should meet their needs. I understand that officials from the Department of Health and Social Care are currently engaged in discussion with the Children and Young People's Health Policy Influencing Group on the development of that guidance, which is really encouraging.

[Baroness Meacher]

I hope the Minister understands the reason for this amendment. Given that the Minister in the other place has shown his commitment to the principle of issuing guidance, our purpose here is to ensure that the guidance is published and will have statutory force to ensure compliance with it. I shall not go into the details of the amendment, but those are its objectives. I hope the Minister will be able to agree to this amendment, as it does nothing more than ensure that his colleague's commitment in the other place is honoured by the new system. I beg to move.

The Lord Speaker (Lord McFall of Alcluith): My Lords, the noble Baroness, Lady Masham of Ilton, is taking part remotely, and I invite her to speak.

Baroness Masham of Ilton (CB) [V]: My Lords, I have my name to Amendment 98. I am very pleased to support the noble Baroness, Lady Tyler of Enfield, in this amendment, so that the safeguarding of children has an important place in this Bill.

Vulnerable children's needs must be highlighted. It is not long ago that six year-old Arthur and the little girl called Star were cruelly murdered, and the chances of saving them were missed. Over the years, there have been many other shocking cases where children were tortured and killed. It is vital that all the safeguarding people involved in the many tragic cases of vulnerable children work together. It should not be left to one junior social worker, who may be frightened of facing difficult, devious and cunning parents. I hope that the Government agree on the need to upgrade safeguarding children's needs and will help to see that it is in the Bill. The needs of children should not be passed over and neglected.

I also support many other amendments in this group.

11.15 am

Baroness Tyler of Enfield (LD): I rise to speak to Amendments 51, 98, 141, 151 and 162 in my name and, briefly, the other amendment to which my name is attached. I shall make one opening remark. This group is all about children and young people. I know that all noble Lords feel very strongly about this issue. Children and young people make up 30% of the population but are not mentioned anywhere in the Bill.

Amendment 51 would require integrated care boards to share relevant information and data with key partners in the children's system and to collect multiagency data from those partners. As the Bill stands, there are a number of crucial areas in which adults are, rightly, set to benefit from improvements to integrated working in ways that children are not. One of the most concerning ways in which it feels to me as though children have been an afterthought in the Bill is in the sharing of data and information.

Barriers to sharing information have been identified over many years as a key barrier to better joint working, commissioning and delivery of services but, due to the invisibility of children in existing data-sharing legislation, the children's system faces even greater barriers to sharing information than that for adults. However, the measures to improve the sharing of information and data in Part 2 apply only to the adult system. Frankly, I find that inexplicable.

Alongside the noble Lords, Lord Bichard and Lord Hunt, to whom I am very grateful for adding their names to my Amendment 51, I heard numerous accounts of the huge challenges that the NHS and local authorities face in collecting, sharing and interpreting data as part of the recent Public Services Select Committee inquiry into child vulnerability. We heard this time and again. I quote just one sentence from the report:

"poor data-sharing between Government departments and local agencies endangered vulnerable children and their families by undermining safeguarding arrangements and preventing referrals for early help."

As we heard from the noble Baroness, Lady Masham, following the heartbreaking murders of Arthur Labinjo-Hughes, Star Hobson and other vulnerable children in this country, it is essential that arrangements for data sharing between the health system and local authorities for babies, children and young people are urgently improved. As I have said, Part 2 focuses on data sharing between health and adult social care but does not extend this to the children's system. It is not just that children are not specifically included in the wording of the Bill; they have been explicitly excluded.

As the noble Baroness, Lady Meacher, said, colleagues in the sector, including the National Children's Bureau—to which I am very grateful for its help and support on these amendments—have engaged in discussion with officials on this issue. I was pleased to hear that this engagement is going well and is set to continue, but I hope to secure today the Minister's agreement to look again at this issue, which is in the best interests of vulnerable children in this country.

Amendment 98 would add the discharge of duty as a safeguarding partner to the general duties of ICBs in Clause 20. It would require new regulations that specify how ICBs should perform the statutory child safeguarding duty when it is transferred to them from CCGs, which are obviously abolished as a result of the Bill. Although the statutory guidance *Working Together to Safeguard Children* already sets out the responsibilities of a safeguarding partner, the recent tragic events that I have just referred to show that a more robust legislative approach is needed to ensure that children are properly protected by a really effective multiagency safeguarding system.

It was heartbreaking, and I know that all noble Lords in the Chamber were shocked when they heard the details of the tragic death of Arthur Labinjo-Hughes, a six year-old boy who suffered prolonged abuse and was murdered by the very people who were supposed to keep him safe. I recently met the NSPCC, which highlighted government data showing 536 incidents involving the death or serious harm of a child due to abuse or neglect in 2020-21.

Sadly, young Arthur's case is only one of far too many, but health practitioners such as GPs, nurses, midwives and health visitors are in a prime position to recognise and report safeguarding concerns; during medical examinations they might identify signs of physical or sexual abuse. Missed medical appointments

can also indicate neglect. As the strategic safeguarding leader, the ICB will be responsible for ensuring that health practitioners are fully supported to work with other agencies on safeguarding and promoting the welfare of children. Alan Wood's review from 2021, which has been discussed in the Chamber on a number of occasions, makes clear recommendations on strengthening the existing safeguarding arrangements, which came into effect in 2019, including by ensuring effective leadership, data sharing and scrutiny. The Bill offers a golden opportunity to act on these amendments to bolster local health partners' role as a lead safeguarding partner and to embed effective joint practices that really do keep children safe.

Amendment 141 would require NHS England to assess how well an integrated care board has met the needs of children and young people in its area. In order to make a judgment about this, the amendment would require NHS England to publish an accountability framework for setting out national priorities for children and young people. Among other things, ICBs will have a crucial role in commissioning primary and community healthcare services directly for children and young people. They will play a key role in jointly commissioning services for disabled children and those with special educational needs, and in contributing to education, health and care plans, and they will be crucial in commissioning the joined-up services in the first 1,000 days of life, which the Government, to their credit, are investing in.

However, as we all know, there is unwarranted variation, with the support that children and young people receive in the health service often based on where they live rather than on their level of need. This amendment would create much needed accountability for integrated care boards and provide an overarching framework for children's health that ICBs can work within, importantly without being prescriptive in any way about how local systems fulfil their duties.

Turning to Amendment 151, Clause 21 requires every integrated care partnership to develop an integrated care strategy. The amendment would require ICPs to consider specifically the needs of babies, children and young people when developing this strategy. I think the Minister knows my concern and that of other noble Lords—the noble Baroness, Lady Meacher, referred to it—that if we do not refer explicitly to children in the Bill, they will not be given priority equal to the adult population's when it comes to implementation. Sadly, experience shows that when legislation does not explicitly require health systems to consider children, they are often overlooked in subsequent implementation.

Children and young people have distinct development needs. They use a distinct health and care system staffed by a distinct workforce with its own training, and they are covered by distinct legislation. Simply hoping that integrated care systems will take full account of that of their own accord will just not cut it. A more robust legislative approach is needed. Like the noble Baroness, Lady Meacher, I was also pleased to hear that the Minister in the other place recognised the importance of focusing on children and families in the new ICS structures and made a commitment that the Government would develop bespoke guidance for integrated care systems on meeting the needs of babies, children and young people. That is why I support Amendment 177 in the name of the noble Baroness, Lady Meacher, and to which my name is attached, to put this guidance on a statutory footing.

Amendment 162, on Clause 26, would require the Care Quality Commission to work jointly with Ofsted to plan and conduct reviews into the provision of health and children's social care in integrated care board areas.

Again, I refer back to my experience as a member of the Lords Public Services Select Committee. I can confirm, as the noble Lord, Lord Hunt, will be able to, that the committee investigated the role played by the relevant regulators and inspectorates. Indeed, we took evidence from the senior leaders of the relevant inspectorates and regulators, specifically Ofsted and the CQC. Our conclusion was that, despite the very best intentions, these inspectorates do not work together closely enough or have a truly integrated approach. It is telling that our report revealed that the CQC itself called on the Bill

"to give it the 'ability to look at [the] care of children across all settings' as part of its regulation of Integrated Care Systems".

I believe that the Bill should give the Care Quality Commission and Ofsted powers jointly to hold integrated care systems, service providers and local decision-makers accountable for the long-term outcomes for children's health, including health inequalities.

I very much support Amendment 177 in the name of the noble Baroness, Lady Meacher. It has been explained and it very much goes with the grain of my other amendments.

I also strongly support Amendment 142 in the name of my noble friend Lady Walmsley, which would provide an opportunity for the Government to ensure that children and young people are prioritised on ICBs while maintaining local flexibility, which is important. An impact assessment would allow for good practice to be shared quickly and for both Houses to exercise effective scrutiny over the implementation of this legislation.

On Amendment 87 in the name of the noble Baroness, Lady Finlay, the idea of the appointment of a strategic clinical lead for children and young people's health is an excellent proposal, but I will leave the noble Baroness to express that.

In conclusion, the Government have a very important agenda for children. There are a lot of things that they are trying to do. I strongly support most of them but I really feel that we must have an effective legislative framework to allow that agenda to be taken forward successfully.

Baroness Finlay of Llandaff (CB): My Lords, this group of amendments is particularly important because it concerns the next generation, addressing children and young people's health and social care needs. As has been said, I have tabled Amendment 87. I have also put my name to Amendments 141, 151 and 162, introduced so comprehensively by the noble Baroness, Lady Tyler. I also support the other amendments in this group.

[Baroness Finlay of Llandaff]

These amendments address how the needs of children and young people aged nought to 25 will be met by the relevant healthcare and social care provision within the area of each integrated care board. A bonus from recognising this in the Bill would be the encompassing of young people with learning difficulties and autism, whom we discussed last week.

I was struck by a figure raised during the debate in the other place. According to Young Minds, 77%—more than three-quarters—of sustainability and transformation partnerships failed to consider children's needs sufficiently. Only one of the 42 ICSs in existence listed a strategic lead for children and young people. Given the range of agencies and pathways, someone must have responsibility for the integration of services at the local level and for listening to the needs of young people.

More than 12.6 million children aged 18 and under live in England, yet the Bill reads as if it is written by adults for adults. Let us not forget that an estimated 800,000 children in England are child carers and more than 250,000 of them are likely to be providing high levels of care for their relative.

Alarmingly, the UK is fifth from bottom among 27 European countries for infant mortality, and one in six children has a diagnosable mental health condition. The number of children in looked-after care is rising and we have heard terrible stories of children whose lives have been lost through abuse and illness.

11.30 am

Child health outcomes in England are worse for children in deprived areas and the inequalities are widening. We have the highest child mortality rate in Europe for children with asthma. Children of school age from the most deprived areas are two and a half times more likely to have an emergency admission for asthma, representing an excess cost to the NHS alone of £8.5 million a year, quite apart from the devastating and frightening nature of asthma. Let us not forget that children die of asthma.

The population of nought to 25 year-olds also have distinct development needs, requiring a specialised workforce to meet those needs and prepare them for adulthood. If they have learning difficulties at any level, the parents also need to be prepared for the legal cliff edge at the age of 18. From one day to the next, the parents can no longer determine decisions on behalf of their child but need a lasting power of attorney or deputyship in place. All this underlines why the voice of children and young people must be heard at board level.

In Committee in the other place, the Government committed to developing "bespoke guidance" for integrated care systems on meeting the needs of babies, children and young people. This is most welcome, but somebody needs to have responsibility for making sure that guidance is acted on and the gap is closed rather than allowed to widen.

Amendment 98 would stipulate such a duty as a safeguarding partner. The NSPCC and the Royal College of Paediatrics and Child Health, to which I am most grateful for meetings and briefings, have highlighted that last year alone there were over 500 incidents involving the death or serious harm of a child through abuse or neglect—an increase of 188 child deaths on the previous year.

The Bill provides an important opportunity to strengthen and support health as a lead safeguarding partner, embedding effective joint working practices within multiagency safeguarding partnerships. But clinical commissioning groups and ICBs are not equivalent bodies. ICBs' larger geographic area means that they must ensure that all healthcare professionals are actively engaged. The clear recommendations in Sir Alan Wood's paper need to be acted on. An ICB lead is essential to make sure that there is an accountable officer, that data and information-sharing happens, with scrutiny of the mechanisms so that a national benchmark can ensure that good practice is disseminated. Amendment 162 aims to ensure a joint framework to hold agencies to account for how effectively they collaborate, to improve long-term outcomes for children. The Bill should give the CQC and Ofsted joint powers to hold integrated systems.

Multiagency arrangements need examining to ensure that the funding is shared equitably and proportionately. Without the lead person, I fear that children and young people will yet again be viewed as an afterthought and ongoing deaths as a tragedy to be looked into, perhaps with lessons learned, but not as the avoidable deaths that they are.

The Lord Bishop of Birmingham: My Lords, on behalf of my right reverend friend the Bishop of London, who cannot be in her place today, I speak in support of Amendment 141, to which she has put her name, alongside all the amendments, which I too support, having listened to the discussion and read them carefully. They all aim to strengthen the services for children and young people. The Government should be congratulated on continuing in the NHS a long period—perhaps 20 to 30 years—of raising the profile of children and young people. The work of the clinical director should be noted, and the involvement of young people in the design of services, although we have already heard this morning that this could be increased.

The pandemic has shown that there are still gaps through which children and young people fall. My right reverend friend the Bishop of London, and myself in Birmingham, are in regular contact with head teachers of Church schools and know about the increase in children's mental ill health, continued inequalities, and the uneven provision of services across the country.

In the second day of Committee, the noble Baroness, Lady Harding, emphasised the need for focus in the NHS. Other noble Lords here have spoken of the need for levers in the Bill to ensure accountability. I think that this is what Amendment 141 attempts to do—to provide such a regular assessment and framework to ensure that the needs of children and young people are always included and that there is a general and regular accountability. I trust that the Minister will consider the amendment carefully, along with the others—but particularly this one—and accept it.

Lord Shinkwin (Con): My Lords, it is a great pleasure to follow the right reverend Prelate the Bishop of Birmingham. I apologise to the Committee for not being able to be here at the start of the debate on this group, owing to a medical appointment.

I shall address my remarks to Amendments 141, 151 and 177. I do so because, like other noble Lords who have put their names to these amendments, and as I made clear at Second Reading, I believe that supporting speech, language and communication development and better outcomes for children and young people with speech, language and communication needs, which I shall refer to as communication needs for the remainder of my contribution, is incredibly important and a cost-effective investment.

I should at this point declare my interest as a proud vice-president of the Royal College of Speech and Language Therapists. I should also say that I have incorporated within my remarks those that would have been made by the right reverend Prelate the Bishop of Gloucester, who has a passionate interest in adequate support for people with communication needs as a former speech and language therapist.

My first point is that these amendments do not come with a significant price tag attached. Indeed, the price tag of not implementing what they propose would be considerably greater. These amendments would actually facilitate cost-efficiency because of the significant benefits over the medium to longer term of getting the system right at the outset—in other words, by ensuring that the system works to maximum effect when it matters most, as early as possible in children and young people's lives.

We know that the impact of not supporting children and young people with communication needs in particular can be significant. For example, children and young people with long-term communication needs—10% of all children and young people—are at greater risk of worse educational attainment, mental health problems, unemployment and potential involvement in the criminal justice system if their needs are not identified and adequately supported. It seems common sense to require NHS England, as Amendment 141 proposes, to assess how well an integrated care board has identified and met children and young people's needs in relation to the national accountability framework, which, of course, it has responsibility for publishing. It would help ensure transparent value for money—in other words, optimal bangs for bucks for the taxpayer. I have to ask: what's not to like?

This amendment gives us the opportunity to ensure that children and young people are prioritised by decision-makers in the health system. Sadly, children and young people with communication needs are often even less of a priority. Indeed, this has been demonstrated by decisions taken during the pandemic, when speech and language therapy services to children were stopped and speech and language therapists were redeployed in many areas. As a result, according to a survey conducted by the Royal College of Speech and Language Therapists, 62% of children and young people received no speech and language therapy during the first lockdown. That is almost two-thirds whose life chances will have been adversely affected, and that will definitely come with a price tag attached over time.

It is therefore vital that integrated care boards are held to account to ensure that they give children and young people the priority they deserve, with a clear set of outcome metrics, including outcomes for children with communication needs. In fact, this would be in line with the Government's very welcome acknowledgement—in a response to a Written Question tabled by the noble Lord, Lord Ramsbotham, in July 2019—that speech, language and communication skills are a primary indicator of a child's well-being.

Surely it makes complete sense that this accountability should be grounded in a national accountability framework so that we actually see equitable support across England and thereby reduce the risk of babies, children and young people and their families facing a postcode lottery of access to services. I assume that all noble Lords would agree that the service they receive should be based on need rather than where they live. I would be very grateful if the Minister could tell me whether the national accountability framework will include metrics on outcomes for children and young people with communication needs.

Amendments 151 and 177 are in a similar vein and would, I believe, also bring considerable cost benefits. Amendment 151 would require an integrated care partnership to specifically consider the needs of babies, children and young people when developing its strategy. As with Amendment 141, to ensure that the Government's very welcome ambitions for babies, children and young people, including those with communication needs, are achieved, it is essential that an integrated care partnership's strategy specifically considers the needs of babies, children and young people so that they can achieve the best possible outcomes, not least in terms of life chances. This would help to develop a holistic, local approach to supporting babies, children and young people and their families, including, of course, those with communication needs.

It is also crucial that the strategy includes plans to support speech, language and communication development at the population level. This would help not only to deliver better health outcomes for children but to tackle health inequalities, an issue that I appreciate noble Lords have already addressed in considerable detail in Committee.

Finally, on Amendment 177, this proposed new clause would require the Secretary of State to lay regulations and publish guidance on how integrated care systems should meet the needs of babies, children and young people. This would also require integrated care systems to act in accordance with guidance. The key point here is that bespoke guidance for integrated care systems on meeting the needs of babies, children and young people must be on a statutory footing if we are to ensure that the strongest possible support is provided, including for those with communication needs and their families. I suggest that only then can we be confident that meeting their needs will not be considered optional and that a potential postcode lottery in access to services and support can be pre-empted and prevented.

11.45 am

Going back to that figure of 10% of all children and young people having long-term communication needs, surely it is important that the guidance includes

[LORD SHINKWIN]
specific reference to such needs. Given the links between early speech, language and communication skills and health inequalities, it is essential that this guidance also includes details on how communication skills will be developed at a population level.

Surely it is in everyone's interests that integrated care systems give due regard to meeting the needs of babies, children and young people, including those with communication needs. These amendments would ensure that that happens and that the significant cost benefits are not only factored in from the outset but realised in the medium to longer term.

Baroness Whitaker (Lab): My Lords, I declare an interest as a patron of the British Stammering Association; indeed, I am a stammerer myself. I regret that I could not join in at Second Reading. I support all the amendments in this group, as does the Royal College of Speech and Language Therapists.

I want briefly to add my support for Amendments 141, 151 and 177. As the noble Lord, Lord Shinkwin, said, Amendment 141 would improve the lot of some 10% of children in the United Kingdom. That is a large proportion. Those are the ones who have identified speech, language and communication needs, which, as has already been said, affect their life chances in many ways. The way to do this, as the right reverend Prelate said, is to have the vital structure of accountability for their needs being identified and met.

There is a big equality issue here. I remind noble Lords that up to 50% of children in areas of social disadvantage start school with delayed language or another identified communication need. The 2010 Marmot review on health inequalities emphasised that

"giving every child the best start in life … is our highest priority recommendation."

The review identified reducing inequalities in the early development of physical and emotional health and cognitive, linguistic and social skills as a priority objective, noting communication skills as crucial for "school readiness". Levelling up is for children too; arguably, it is particularly important for them. The national accountability framework in Amendment 141 must include metrics on speech, language and communication development at the population level and outcomes for children and young people with communication needs.

On Amendment 151, I can do no other than echo the words of the noble Lord, Lord Shinkwin, with whom I agree entirely.

I strongly endorse Amendment 177, which would put the guidance on a statutory footing. One advantage of this, which should be done for all sorts of reasons, is that it would enable the postcode lottery to disappear or at least be very much reduced. Of course, it ought to include specific guidance on supporting speech, language and communication development at the population level, explaining how the needs of children and young people with communication needs will be met. I hope that the Government will pay attention to this often rather neglected aspect.

Lord Scriven (LD): My Lords, I support Amendment 20 in the name of the noble Baroness, Lady Meacher, and in so doing declare my interest, as laid out in the register, as a vice-president of the Local Government Association and a non-executive director of Chesterfield Royal Hospital NHS Foundation Trust.

NHS England defines the better care fund as being there to support

"local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers."

So why is that not the case for 30% of the population, children and young people, who have the same complex needs and the same need for integration as adults do to help and support them on their journeys? The better care fund has been around since 2014. My guess is that this was an oversight rather than a deliberate means to keep children and young people out. Having looked at examples of what the better care fund can achieve in integration and outcomes for adults, I believe that this oversight needs to be addressed. Children and young people need to be on the face of the Bill.

I think that the Government accept that things need to happen, because we have the children's social care innovation programme, which is particularly about looking at innovation in social care along with healthcare partners. The problem, however, is that it is a bidding system and it is not for all local authorities. If you win the bid, you can do it. Children and young people across the country deserve and should expect the right to have innovation in integration to improve their outcomes regardless of where they live. It should not be conditional on their local authority being successful in a bid.

I can see no reason why, as the noble Baroness, Lady Meacher, said, the Government would not want to do this. It is an oversight in the better care fund. Putting children and young people on the face of the Bill would ensure that they received the integration and better outcomes that adults achieve through the fund.

Baroness Bennett of Manor Castle (GP): My Lords, I offer the support of the Green group for all the amendments in this group. My name is attached to Amendments 51 and 87 and it would have been attached to others had there been space. I can only commend the noble Baronesses, Lady Meacher, Lady Tyler of Enfield and Lady Finlay of Llandaff, for identifying a serious lacuna in the Bill and for providing practical, careful and sensible solutions to that.

The noble Baroness, Lady Finlay, said that the Bill was "by adults for adults". The other amendments in the group address only half that phrase. It addresses the "for adults" part but not the "by adults" part, which is what my Amendment 103A aims to address. Young people are experts in being young people. We may think about the life experiences of a 12 year-old or an 18 year-old, but none of us really knows what it is like to be 12 or 18 at this moment. A phrase often used particularly by marginalised groups is "Nothing about us without us"—given the hour, I will spare noble Lords the Latin version.

Young people are undoubtedly a marginalised group in our society in that their voice is far too rarely heard. As I have reflected previously, they are hugely underrepresented in this place and in the other place. The under-18s do not have the vote. The under-25s in

the voting population, for structural reasons that could be fixed but have not been, do not have the same kind of voice.

I entirely accept that, among paediatricians and social workers, there are many older people who have much expert knowledge, but it is crucial that we actually hear. My amendment seeks to address ICBs and sets out that, in statute, there should be an advisory board consisting of young people on every ICB. I believe that this is an important addition to ensure that young people's voices are heard. It might be said that many ICBs may set up such a structure, but that is not the same as it being statutory, ensured in the Bill with a message from Parliament saying, "You have to listen to these young people's voices".

I doubt that I need to address this in detail, particularly with the occupancy of the Chamber for this group, but I want to mention the Children's Society's *Good Childhood Report 2021*, which looked at 10 to 17 year-olds. Among them, one in 15 were unhappy with their lives—the highest level in a decade. We know that children who are unhappy at the age of 14 are significantly more likely to display symptoms of mental ill health, to self-harm or, sadly, to attempt to take their own life by the time they are 17.

As the report makes clear, the pandemic is only part of this story. There is a climate emergency and a pervasive fear about the future that young people have lived their entire lives through. We are talking about people whose whole life experience, virtually, has been since the financial crash. One thing that we know addresses a sense of powerlessness, with all its negative effects on mental and physical health, is giving people a sense of empowerment—that is, a sense that they can take control of their lives, make choices and make a difference. I often see this with young climate strikers.

I believe that the measure proposed by my Amendment 103A would ensure that this group of amendments collectively addresses the two sides of the problem that the noble Baroness, Lady Finlay, identified. I want to take this forward and I invite noble Lords who are interested to talk to me about it. This should be included in the Bill. Let us hear from children and young people and make sure that ICBs listen to the children and young people they serve.

Lord Hunt of Kings Heath (Lab): My Lords, I very much agree with the noble Baroness and I support the broad thrust of these amendments. As this is my first intervention on the Bill, I should declare my interests as a board member of the GMC and the president of GS1 UK, the British Fluoridation Society and the Hospital Caterers Association. I am also a trustee of the Foundation for Liver Research.

I support Amendment 51 in the name of the noble Baroness, Lady Tyler. As she said, she, the noble Lord, Lord Bichard, who also put his name to the amendment, and I are members of the Lords Public Services Select Committee, which has just produced a report on vulnerable children. When taking evidence and listening to the arguments, it was sobering to hear that it is now estimated that the number of vulnerable children has accelerated, particularly during Covid, so that more than 1 million children are growing up with reduced life chances. Too many of them end up in our criminal justice system but, despite this, there is no government strategy to deal with vulnerable children.

The result is a lack of co-ordination both nationally and locally. Too many children fall through the gaps. Public services intervene far too late to prevent some of these children from getting into difficult circumstances. Although the amendment deals with only one aspect, it is but one aspect of a more general problem that we believe the Government need to address. The particular problem that we wish the Committee to take account of is the silo working that continues to be evident both nationally and locally, as well as the frustrating unwillingness of public bodies to share data even though it is abundantly clear from both the law and the Information Commissioner's comments that they are perfectly able to do so.

I do not pretend that passing an amendment to the Bill will change everything overnight, but we look to the Government to be firm in their intent. It is unacceptable for public bodies, many of which have a direct relationship with government, to refuse to share information for all the miserable reasons of tribalism and managers not being willing to let go. We need to do something here.

Noon

Lord Polak (Con): My Lords, I am pleased to speak immediately after the noble Lord, Lord Hunt. I am sure that he has, like me, a feeling of déjà vu. We were here not so long ago talking about the Domestic Abuse Bill, when I and many Members here today urged the Government to put children in the Bill. I am pleased that the Government listened, although it took some time and a lot of effort—that is why I am pleased to support the noble Baroness, Lady Meacher, on Amendment 20. It seems clear to me that children should be front and centre in this Bill, as we made them in the Domestic Abuse Bill.

We have worked closely with Barnardo's, which has advised many of us, and I know that it raises three issues here: to protect the needs of young carers; to mandate that the child impact assessment is undertaken by the Government within two years of the Bill's implementation to assess its impact on children; and to clarify and prioritise the better care fund so that it can be used to achieve service integration for children. I do not want to take time—I just think that my noble friend the Minister may want to look at *Hansard* and our debates on the Domestic Abuse Bill. I am sure that he will find a way to put children front and centre in this Bill.

Baroness Walmsley (LD): My Lords, this morning the Committee has heard from the noble Baronesses who have spoken to amendments many good reasons why it would be helpful to the Government's agenda to improve services for children, if children were referred to explicitly in several places in the Bill. I hope that the Minister will be able to consider this matter and see whether there is anything that he can do about it.

I have Amendment 142 in this group. New Section 14Z57 in Clause 20 is about performance assessment of the integrated care boards; it contains several important measures, but one is one missing.

[Baroness Walmsley]

This amendment would mandate that, two years after the Bill is implemented, a child impact assessment should be undertaken by the ICS annually to assess its impact on children. This would provide the information to enable NHS England to do the assessment which Amendment 141 requires it to do. I very much support all the amendments, particularly those that would gather information, publish it and enable its sharing, because that will help. We know that early intervention works, but we do not know where to intervene unless we know what is going on, and that is why these things are very important.

There is no duty in England for government to assess and publish the effects of legislation on children—neither is there a duty in this Bill on the ICS. It was in about 2010, I recall, that the then Government committed to regularly assess the effect on children of relevant legislation, although it is not mandatory to do so and it is often not done, despite the fact that Nadhim Zahawi, now Education Secretary, when he was Children's Minister in the Department for Education said:

"The use of children's rights impact assessments is widely promoted across the Department and wider Government".—[*Official Report*, Commons, 24/6/19; col. 447.]

Well, I hope so.

Scotland and Wales have taken a slightly different approach; they have systems to assess the effect of devolved legislation on children. I have to say, as a proud resident of Wales, that those two nations have always led the way in relation to children's rights.

As others have said, this is a very adult-focused Bill, but there are more than 12.6 million children aged 18 and under living in England, compared to just under 10.5 million of 65 year-olds and over—people like me. As drafted, the Bill does not explicitly recognise the health and well-being needs of those children and young people, who, as we have heard, have very specific needs and no voice and are often more dependent than adults on integrated services. They could benefit from the Bill perhaps more than any other group.

We know that around half of mental health disorders start at the age of 14 to 16 and that, although research has shown that around 30% to 40% of the risk of anxiety and depression is genetic, 60% to 70% is environmental—and we can change the environment. I am grateful to Barnardo's for these figures. In addition, this generation, from infants to older teenagers, will have had their physical health and mental well-being impacted by the pandemic, and in just over a decade, over half of this group will have left school and entered further and higher education or the workforce. Other amendments will allow the ICBs to gather information and share it. This amendment would allow them to publish an impact assessment, which would help NHS England to publish what it has to publish.

The Government cannot meaningfully address the challenge of improving overall population health without tackling child health inequalities. The success of the Bill should be measured by its practical and tangible impact in ensuring children and young people's access to timely and appropriate health and care services, and ultimately in doing what the Government want to do: improving health outcomes for the whole population.

Lord Laming (CB): My Lords, the House will recognise that children have very different needs. They are vulnerable in many ways and in need of the recognition that all the services have to work together. It seems strange that in a Bill on health and social care, children are not identified as a special group. I support these amendments.

Baroness Wheeler (Lab): My Lords, today's debate has shown the strength and depth of feeling across your Lordships' House that children and young people should be properly provided for within the scope of the Bill and not just as an afterthought, as many noble Lords have said.

Intervening in the early years of a child's life is the most effective way of shoring up their good health and well-being as an adult. This group of amendments seeks to do just that, ensuring that our children are not sidelined in a healthcare infrastructure currently designed with adults, and just the NHS, in mind. This group also seeks to strengthen the Bill by including safeguarding, interagency working, service integration and data sharing, especially between government departments and the NHS and social care.

I thank noble Lords for putting forward these amendments, particularly the indefatigable noble Baroness, Lady Tyler, for her proposals across Clauses 20 and 21 to ensure the joining up of the roles and work of ICBs and ICPs in these crucial areas. Indeed, what is particularly striking about today's debate is that the experience and contributions of noble Lords have joined up children's needs across a whole range of service provision and support in a way that government structures currently fail to do. This is a major issue that needs to be addressed, particularly to address the needs of vulnerable children, as my noble friend Lord Hunt and other noble Lords have stressed.

If the Bill is to stand any chance of improving government health outcomes, it must start with the youngest among us all. Right now, in this, the fifth-biggest economy in the world, child health inequalities are widening, while 25% of children in the average reception class will be overweight. By the time those children are in year 6, it will be 40%. The all-cause mortality rate for under-14s in the UK is among the worst in Europe, and the World Health Organization tells us that 50% of lifetime mental illnesses start by the age of 14. Noble Lords will recall the debate last week about the need for robust mental health services, which include those around potential young suicides, self-harm and eating disorders. As the charity YoungMinds reminds us, after-care and follow-up are crucial although, sadly, ignored in current sustainability plans, as the noble Baroness, Lady Finlay, pointed out.

The Royal College of Paediatrics and Child Health has expressed particular concern that there is currently no duty in the Bill to include representation from children's health and care services on integrated care boards. The noble Baroness, Lady Finlay, underlined in her Amendment 87 the importance of safe staffing levels and of this in driving forward improvements in child healthcare outcomes and ensuring that children and young people can access the care they need, when they need it and from the most appropriate person or team.

Barnardo's is similarly worried about the absence of a child impact assessment, without which there will be no clear, objective idea of the impact of the changes in this Bill on young people. The right governance and rigorous evaluation, aimed at providing lessons learned for future service design and reform, can surely only be a good thing. We strongly support Amendment 142 on this issue, in the name of the noble Baroness, Lady Walmsley, which calls for the impact assessment to be undertaken within two years of the Bill's implementation. It also emphasises the need for an annual report and debate in Parliament on the impact of changes, scrutinising, in the first year in particular, how the changeover from CCGs to ICBs is working in practice.

Following last week's debate on the appalling backlog of waiting lists and the NHS's duties under the mandate and constitution, I remind the Committee that last month's National Audit Office report showed that more than 288,000 children and young people are waiting for NHS treatment, 86,000 of whom have been waiting for longer than the 18-week target I asked the Government to reaffirm.

Whether it is ensuring proper information sharing between care providers, safe staffing levels or clarifying how the Better Care Fund can specifically be used to better integrate children's services, these amendments have compassion and common sense behind them. We have an opportunity in this Bill to give our children a healthier future. I hope that the Minister will agree.

Lord Mackay of Clashfern (Con): My Lords, I am sorry to intervene at this stage but I cannot let the opportunity pass to say, in my view, how important it is that children be particularly referred to and their circumstances be properly taken into account. We have very powerful legislation on the care of children, but the same is not true with health, and it is extremely important that that be kept in view. Apart from anything else, special staff and treatments are required for children, and I therefore strongly support this amendment. I am sorry that I was not able to do so at a more appropriate time, but I arrived a little later than I would have liked.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord Kamall) (Con): My Lords, I begin by thanking all the noble Lords who have tabled these amendments for debate, and noble Lords from across the House for their eloquent contributions. As the noble Baroness, Lady Wheeler, rightly said, it is important that, as the fifth-largest economy in the world, we treat all our citizens equally and give them the respect and access to services they deserve. As she also said, the strength of feeling across the House on the importance of this issue is clear, and this was amplified most eloquently by my noble and learned friend Lord Mackay of Clashfern.

With your Lordships' agreement, I will look at some of these amendments from a different perspective. Each amendment touches on a different aspect of providing health and care for children. Before I turn to matters of detail, let me say that we believe that the Health and Care Bill's proposals represent a huge opportunity to support and improve service planning and provision and ensure that they better meet the needs of infants, children and young people.

With your Lordships' permission, I will start by addressing Amendment 20, which was spoken to so eloquently by the noble Baroness, Lady Meacher, the noble Lord, Lord Scriven, and my noble friend Lord Polak. It would clarify and prioritise how the Better Care Fund could be used to integrate services for children. I remind the Committee that the relevant legislation does not prevent the use of the Better Care Fund for the integration of children's services. The disabled facilities grant within the BCF is already used to fund housing adaptation for individuals aged under 18 with disabilities. Some areas also extend the scope of their BCF-funded initiatives to include integrated services for children and young people.

However, we can go further. The Government believe that integrated care partnerships and integrated care boards represent a huge opportunity for partnership working. The Bill explicitly requires integrated care partnerships to consider whether needs could be met more effectively under Section 75 of the NHS Act 2006, which provides for arrangements to be made between NHS bodies and local authorities. The Government are also working on bespoke guidance on the measures that statutory bodies should take to ensure that they will deliver for babies, children and young people.

Turning to Amendment 51, I particularly welcomed the contribution of the noble Lord, Lord Hunt of Kings Heath, on vulnerable children. The amendment would require ICBs to share and collect information from partners when arranging for the provision of services for pregnant women, women who are breastfeeding and young children. I sympathise with the amendment, and in fact, I would go further: one of my three big priorities in my departmental portfolio, as the Minister for Technology, Innovation and Life Sciences, is to push digitalisation and sharing data. As all noble Lords have rightly said, that is not just for children's services but right across the sector. We hear stories almost every day of something that could have been prevented, had data been shared more appropriately.

12.15 pm

Even asking your GP to put your data on the NHS app is not as simple as it should be. When I asked my GP to do so—I did not tell them that I was a Minister, although maybe I should have; however, I do not like to pull rank—I was told that I had to write to them. I sent an email to my GP's surgery but to this day, the data is still not on there. That shows that the problem in making sure that we can share data and have a common architecture through which we can access it in an appropriate manner, from a trusted research environment, is not just the technology; we must also tackle the culture and the processes to make sure that data is shared. Even though we have put into the Bill provisions on data, which noble Lords will discuss later, it is not enough to say that we need a trusted research environment or to lay out a shared architecture. We must make sure that we drive that culture right across the health and social care system.

This amendment would position integrated care boards as a central repository of data in the health and care system, a function that we do not believe they are well placed to take on. As a result, I regret that we

[Lord Kamall]
cannot agree to the noble Baroness's proposals. We completely agree that data has to be shared, but we see the health and social care information system known as NHS Digital as the national information partner to the whole health and care system in England—one that can better collect data and share information. I was having a conversation with an NHS manager the other day, and it is clear that there is some confusion over data. We have to distinguish between management and performance data, and patient data. Right across the health and social care system, an awful lot of time is spent on the telephone by people centrally, wanting to collect data and thereby blocking patients getting through to services they want to access. If we had the right data architecture, a lot of management and performance data would automatically be shared. That would improve the system, making sure that patients can be treated and that clinicians are aware of their data records wherever they happen to be—especially in emergency situations when they are far from home, but also daily in our healthcare system.

That is why we believe it is more appropriate for the health and social care information system, NHS Digital, to be the data partner for the whole system. We have tasked it, through the Harnessing Digital Technology workstream of the Maternity Transformation Programme, to focus on the interoperability of different records. Noble Lords will be aware that the Bill makes sure that data can be better shared right across the system, to a standard, ensuring that in some areas where data is not shared, such as GP patient records, it is better shared across the system.

I turn to Amendment 87, in the names of the noble Baronesses, Lady Finlay and Lady Bennett. It would require integrated care boards to drive improvements in child health outcomes, including through appointing a children and young people's health lead. As your Lordships will be aware, the Bill already contains measures that require ICBs to secure continuous improvement in the quality of services and in the related outcomes, and that includes outcomes for children. ICBs will also be required to ensure that health and care services are provided in an integrated way when this would improve outcomes, but also—the noble Baroness, Lady Finlay, referred to this—when children reach the cliff-edge age whereby they are no longer considered children, but part of adult services.

There is also existing legislation—the Children's Act 2004—that will require local authorities to make arrangements with ICBs to improve the well-being of children. As a result, the Government do not think that an extra duty would be helpful here, even if we agree with the spirit of it.

I want to take a moment to draw the Committee's attention to some of the work already going on in this area; I thank noble Lords from across the House for acknowledging some of the work that the Government are already doing in this area. To deliver the commitments in the *NHS Long Term Plan*, children and young people's senior responsible officers have been appointed at a regional level, as well as children and young people's leads in integrated care systems. In addition, there will be wider clinical leads for children and young people in ICBs, including leads for children's mental health, learning disability and autism, and overseeing specialised commissioning functions.

Amendment 98 would require the Secretary of State to lay regulations to provide formal guidance on how the ICB must perform its duties as a statutory safeguarding partner. I hope I can reassure the noble Baronesses, Lady Tyler and Lady Masham, that this amendment is unnecessary as all the existing statutory duties of clinical commissioning groups—CCGs—will be transferred to ICBs anyway, including the child safeguarding responsibilities set out in the Children Act 2004. The chief executive will take on responsibility for their local health system's part in multiagency child safeguarding arrangements and the 2018 statutory guidance, *Working Together to Safeguard Children*, will be updated accordingly.

Amendment 103A in the name of the noble Baroness, Lady Bennett, would require ICBs to consult an advisory board comprised of young people on matters of youth ill-health prevention and treatment provision. I acknowledge the noble Baroness's concerns and hope that I can provide some reassurance as to our commitment to public involvement. Our intention with the duties we are looking to place on ICBs is to establish a comprehensive framework of requirements while allowing them significant flexibility to deliver it in a way that best suits local needs.

This includes a provision relating to the public involvement of all ages and requires ICBs to make arrangements to ensure that the individuals for whom services are being or may be provided are involved in the ICB's decision-making on commissioning. The provision covers those health services relating to the care and prevention of illness among children and young people. It means that ICBs already need to ensure that young people are appropriately consulted in a way that best suits their local system needs. I hope that this will reassure the noble Baroness, who I am sure does not wish to create a duplicate provision.

Amendment 141 was tabled by the noble Baroness, Lady Tyler, my noble friend Lord Shinkwin and the noble Baroness, Lady Finlay, and eloquently spoken to by the right reverend Prelate the Bishop of Birmingham on behalf of his colleague, the right reverend Prelate the Bishop of London. It would require NHS England to publish a national accountability framework for children and young people and to use that framework to assess the boards. Again, I hope that I can give some assurance that this is already provided for in the Bill.

Under new Section 14Z57, NHS England

"must conduct a performance assessment of each integrated care board"

and produce a summary report. The assessment will look at a number of issues, including improvement in the quality of service and reducing health inequalities. It will also apply to all age groups; indeed, much of today's debate and noble Lords' contributions touched on some of the issues that we covered in the earlier debate on tackling health inequalities; I know that noble Lords across the House share those concerns.

Further, under the new section, NHS England

"must consult each relevant Health and Wellbeing Board … on any steps that the board has taken to implement any joint local health and wellbeing strategy",

which is based on the assessment of relevant local needs and keeps that connection to place below the level of the ICB. As a result, I would gently advise against creating a separate national accountability framework solely for babies, children and young people simply because this would create an additional burden and risks creating confusion between accountability frameworks. We want to make sure that we have proper accountability and avoid confusion.

Amendment 142 in the name of the noble Baroness, Lady Walmsley, would require ICBs to set out in an annual report how they are meeting the needs of children and young people. I assure the noble Baroness that, under new Section14Z56, to be inserted by Clause 20, each ICB is already required to prepare an annual report on the discharge of its functions, and NHS England can provide guidance as to its content. We expect that, in preparing its report, the ICB would set out how it is meeting the needs of babies, children and young people. We believe that a report focusing exclusively on children and young people is unnecessary and likely to duplicate existing work.

Amendment 177, also endorsed by the noble Baroness, Lady Whitaker, and in the name of the noble Baroness, Lady Meacher, would require the Secretary of State to lay regulations and publish guidance on how integrated care systems should meet the needs of babies, children and young people. I hope to reassure the noble Baronesses that we are already working with NHS England, the Department for Education and stakeholders on bespoke guidance for bodies in local systems on the measures they should take to ensure they will deliver for babies, children and young people. This will include guidance on the exercise of functions currently conferred on CCGs that will be taken up by ICBs, including children's safeguarding, and on children with special educational needs and disabilities.

I hope that I can assure the noble Baronesses that going further than this by requiring the Secretary of State to publish regulations may well interfere with the ability of ICBs and ICPs to innovate to best meet the needs of the babies, children and young people in their local population.

Amendment 162 would expand the Care Quality Commission's duty to include children's social care in co-ordination with Ofsted. I gently suggest that the existing clause already allows the CQC to look at the provision of health and public health services for both adults and children. It can also look at the transition between children's and adult social care and would be able to look at the system's role in that transition in these reviews. In addition, it already looks at the safeguarding of children in health care and the provision of healthcare to children who receive social care.

In addition, existing provisions can and do allow for the CQC to work jointly and proactively with Ofsted, for example on joint targeted area inspection or special educational needs and disability—SEND—inspections. For the CQC to look at children's social care as proposed by this amendment would also risk duplicating Ofsted's role. The existing mechanisms are already an effective way for the CQC and Ofsted, as well as other organisations, to work jointly, and I am slightly concerned that any further amendment risks undermining that, which I know the noble Baroness does not intend.

Amendment 151 would require an ICP specifically to consider the needs of babies, children and young people. Once again, I hope that I can assure noble Lords that this is already our intention. The Bill states that the ICP strategy must set out how assessed needs will be met by the ICB, NHS England or the responsible local authorities. "Assessed needs" includes the needs of all children and young people aged nought to 25. If this amendment were to be accepted, it could affect how the clause is interpreted by suggesting that other population groups are not in scope or of lower priority.

In addition, the September 2021 ICP engagement document sets out that the ICP should highlight in its strategy where co-ordination is needed and specifically clarifies that this includes action to improve the life chances and health outcomes of babies, children and young people. Our bespoke guidance for ICBs and ICPs on babies, children and young people will cover the importance of ICP integrated care strategies having clear objectives for these populations.

Some noble Lords raised the sad and distressing cases of Arthur Labinjo-Hughes and Star Hobson. The Government have been deeply saddened, as have all noble Lords, by these tragic cases, and are undertaking urgent action to seek the answers we need. The Child Safeguarding Practice Review Panel is conducting a national review into these cases and what improvements are needed by the agencies that came into contact with them in the months before Arthur's death. A joint targeted area inspection has also been commissioned to assess the effectiveness of child protection arrangements in the relevant safeguarding agencies. Together, these two actions will establish what national lessons need to be learned and how local agencies can work together to keep children safe.

I am grateful to all noble Lords who have spoken in this important debate, raising incredibly important issues but in an emotive way. I hope I have been able to give some reassurance that these matters are taken seriously by the Government. However, as the noble Baroness, Lady Wheeler, said, noble Lords should be in no doubt that I understand the strength of feeling of the Committee. This will need further conversations with noble Lords who have spoken today and those who have tabled amendments, as well as with others. I hope, for that reason, that noble Lords will feel able at this stage to withdraw or not press their amendments.

12.30 pm

Baroness Meacher (CB): My Lords, I say a huge thank you to and congratulate Members from across the Committee who have made the most amazingly powerful contributions to this debate on the children's amendments. I think that we are all just taken aback that there is no mention of children in these crucial clauses. I confess that I was very disappointed in the Minister's response; we do not seem even to have managed to persuade the Government that the Bill should mention children somewhere, so I think that a number of us will want discussions with him before Report to see whether we can make some

[Baroness Meacher]
progress on making sure that children in future are taken care of. On that basis, I beg leave to withdraw my amendment.

Amendment 20 withdrawn.

Clause 10 agreed.

Clauses 11 and 12 agreed.

Amendment 20A

Moved by ***Baroness Barker***

20A: After Clause 12, insert the following new Clause—

"Appointment of a National Clinical Director for Women's Reproductive Health

NHS England must appoint a National Clinical Director for Women's Reproductive Health."

Member's explanatory statement

This amendment would require NHS England to appoint a clinician to provide national clinical leadership, advice, input and support on issues relating to reproductive healthcare.

Baroness Barker (LD): My Lords, I declare an interest as the co-chair of the All-Party Parliamentary Group on Sexual and Reproductive Health. At Second Reading, I said that it was not at all clear exactly what contribution the Bill would make to the strategic aims that all parties have to turn the NHS into a body that is preventive, forward-looking health promotion service, which concentrated far less on the acute sector and looks at population health much more strategically while making greater use of technology and, in doing so, seeks to reduce health inequalities. On day 3 of the detailed examination of the Bill in Committee, I am still no clearer about that.

In every set of amendments that noble Lords have put forward, they have tried to ascertain from the Government exactly how the Bill will achieve that aim—and, as yet, the answer is unclear. But if the Bill is about anything, it is about enabling those within the NHS, as well as patients and interest groups that work with them, to take what we have as a National Health Service at the moment and introduce into it new and innovative ways of looking at conditions, to build different pathways and processes of treatment in order to bring about the much-improved health outcomes that we believe are possible from the NHS.

In this amendment, I am very much influenced by the 2009 report from the Royal College of Obstetricians and Gynaecologists, *Better for Women*, which did exactly that: it took a longitudinal life-course investigation of women's health needs. The report decided that the way health services have traditionally been provided is lacking, because it is by and large built on some fairly old established ways of thinking from a provider's perspective rather than from the perspective of women and their partners. In terms of reproductive health, the RCOG report showed, with a number of different stakeholders, the many different ways in which we could look at women's health and achieve far better outcomes.

The RCOG report started by looking at the data on reproductive health. Bear in mind that reproductive health is unique. It is perhaps the one area of medicine in which the people engaging with health professionals are, for the most part, not ill. They are in need of medical intervention and occasionally surgical intervention, but by and large they are not ill. They are going through a process that is natural but needs the informed intervention of health professionals. It is very different from other areas of acute medicine.

We have a national health service and all the years of experience behind that, yet we currently have very poor outcomes for women. Almost half of British women experience very poor reproductive and sexual healthcare. It is estimated that about 45% of pregnancies in the UK are either unplanned or there is ambivalence, and that is after decades of different Governments making concerted efforts to deal with unwanted pregnancies. The abortion rate is probably the highest it has been since records began and, crucially, access to contraception, and to particular forms of contraception, including long-acting reversible contraception, is now in significant decline. Also crucially, cervical screening for eligible women is at 70%, significantly below the national target of 80%.

This is largely due to one simple fact: we have completely fractured service provision. We know that reproductive health services were traditionally part of primary care; indeed, access to information about reproductive health services was part of the education service. We know that an element of women's reproductive health will always have to sit in the acute sector, yet in all these years we have failed to build a coherent system that works with the three different elements—primary care, acute care and the education system—and in which women can access what, by and large, they know they need.

For some sections of our community, the outcomes are even worse. We know that the figures are much worse for women from black and minority ethnic communities. Eight per cent of abortions occur in women who report as being black, but that is in 3% of the general population. We also know that black, Asian and minority ethnic women also have much worse outcomes in maternity services. Only of late has that begun to be looked at and systematically analysed by one or two very good, interested professionals in maternity units.

The amendment, which calls for a national director, was tabled to highlight the case for having somebody in the leadership of the NHS who can look at the whole question of information for women, access to services and the different outcome statistics for different methods of arranging reproductive health services. We have different arrangements in the four nations of the United Kingdom because this is a devolved matter, so we can have comparative statistics to see which approaches work better.

If we follow the lead set out in the RCOG report, we can have an inclusive approach to women in all their diversity, and inevitably we will look at systems that are beneficial to men. Clearly reproductive health has a particular impact on the lives of women, but men are included too.

It seems to me that, if this Bill and the flexibilities in it are a route to better outcomes, this is perhaps one way in which we could try to have innovation at the centre. It impacts in different ways throughout the

system, which hopefully will be integrated between local government, primary care and tertiary care. It is in that spirit that I beg to move the amendment.

Baroness Walmsley (LD): My Lords, I support my noble friend's proposal for this simple reason: it would enable focus on the very particular needs of women's reproductive health. As we heard earlier in our debate, children have specific needs. Well, so do women, particularly with reference to their reproductive cycle.

I am particularly keen on the element of prevention of ill health. Many services for women focus on it. Obviously, we all have cause to be grateful for the breast and cervical screening services that are available; I was professionally involved with them many years ago. It is also, however, cause for concern that the number of women taking advantage of those important preventive services has been falling. A national lead would have the expertise, responsibility and ability to focus on areas where women need to be encouraged to take advantage of the services that are available to them.

There must be concern about the quality of maternity and perinatal services, given some of the dreadful cases that we have heard about and the poor quality that has been rife in a few centres in the country in the past. I hope that things are being put in place to improve that, but there is an element of prevention here too. Good-quality maternity services prevent women and their babies having a bad experience at the beginning of their life together. It is so important for the ongoing mental and physical health of the child that women can bond with their children and babies can bond with their mothers. That bonding starts at the very beginning, but it is less likely to happen with poor-quality maternity services, which of course cost the health services and the country later on.

These services are vital for preventing further problems not just for the mother but for the children. It is the sort of thing that a highly qualified and knowledgeable national lead can focus and advise on in trying to ensure that access to good-quality services is available to all communities in the country. My noble friend Lady Barker highlighted the difficulties that some communities face in getting those good services. I hope that the Minister will consider this amendment in a positive light.

Baroness Thornton (Lab): My Lords, first, I thank the noble Baroness, Lady Barker, for introducing this amendment. Yet again, it is an indication that if this Bill actually presents the opportunities that the Government tell us it does, they need to accept something that recognises the opportunities that are being suggested to them across a whole range of issues, including children, about whom we have just had a very good debate.

The amendment would require NHS England to appoint a national clinical director for women's reproductive health to provide the kind of clinical leadership that the noble Baroness, Lady Walmsley, talked about and to support this important area of women's reproductive healthcare. In recent years, the Government have issued policy papers about women and health, so I would have thought that this particular proposal would chime with that.

We know that almost half of British women will experience poor sexual and reproductive care. It is clear that we can take the opportunity to improve this situation, particularly on the postcode lottery that some women face. I can certainly see, as the two noble Baronesses have said, that a single clinical director for the whole of the UK would give the area energy and focus, particularly for the 50% of women who have not had a good experience. We agree with the Faculty of Sexual and Reproductive Healthcare, which supports this amendment. I am glad of the opportunity to speak on this important issue, and I hope that the Minister may have some good news for us.

12.45 pm

Earl Howe (Con): My Lords, I am most grateful to the noble Baroness, Lady Barker, for bringing Amendment 20A before the Committee today, and to the noble Baronesses, Lady Walmsley and Lady Thornton, for their very wise insights. I do not think there can be anyone in Committee who does not agree that delivering high-quality reproductive healthcare is critical for the health service.

This is definitely a priority area in the Government's work on the women's health strategy for England. Proof of that, I hope, is that on 23 December 2021 we published *Our Vision for the Women's Health Strategy for England*. The vision is informed by analysis of the call for evidence, which ran for 14 weeks from March to June 2021.

On reproductive health specifically, the vision sets out our ambition that

"women can access services that meet their reproductive health needs … and women's experiences of services and reproductive health outcomes are improved".

As a bit of further background, we were clear that the strategy should be evidence-based, so the vision is in fact underpinned by the analysis of what we heard through the nearly 100,000 responses to the call for evidence. We owe it to women and girls across England to get it right, and when we publish our full strategy later this year we will set out our ambitions in more detail and will follow that up with full delivery plans where appropriate.

Joined-up national policy and clinical leadership are essential to the delivery of women's reproductive health services. I can assure the Committee that this is also recognised as a priority by NHS England and NHS Improvement. We continue to work closely with NHS England and NHS Improvement on the development of the women's health strategy for England. We will also be working closely with NHS England and NHS Improvement on the Government's forthcoming sexual and reproductive health strategy to ensure that, together, the women's health and sexual and reproductive health strategies take a holistic and comprehensive approach to improving women's reproductive health. The sexual and reproductive health strategy will consider how we can strengthen leadership and accountability in relation to reproductive health, as well as how we improve access to contraception.

Self-evidently, NHS England regards these as major areas of work. We do not, however, think it appropriate in the Bill to require NHS England to appoint an additional national clinical director specifically for

[Earl Howe]
reproductive health. The first reason is because, within the current NHS England and NHS Improvement, the role of national clinical director for maternity and women's health already exists. This position is responsible for clinical advice and leadership on obstetrics and gynaecology matters, which are of course important areas of women's reproductive health. The post is currently held by Dr Matthew Jolly. The national clinical director works alongside the national speciality advisers for gynaecology and four other national speciality advisers, covering broader aspects of obstetrics and public health. Creating an additional post of national clinical director for reproductive health is likely to be counterproductive, in that it may lead to duplication or less clarity over responsibilities and clinical leadership.

Secondly, as a point of principle, we should try to resist the urge to specify the clinical directors that NHS England should appoint. If we make a habit of doing that, it strips it of its operational autonomy. It is better to allow it to determine the directors it needs, based on the challenges it faces.

The noble Baroness, Lady Barker, rightly pointed out the disparities that exist between different groups of women in this country. I can only express my agreement with the points that she made on that subject. It is essential that we recognise that women are not a homogenous group. The different characteristics that make up each woman's identity can lead to multiple, sometimes overlapping barriers to accessing healthcare and can contribute to disparities in health outcomes.

When we launched the call for evidence that I mentioned, we said that we wanted to better understand where there are disparities between men and women and between different groups of women. As set out in the vision, a key priority running through this work is to ensure that all women have equitable access to and experience of services and that disparities in outcomes are reduced.

In addition, NHS England and NHS Improvement regularly review their clinical leadership, including national clinical director and national specialty advisor roles, to ensure alignment with strategic priorities for the NHS and patients, as set out through the *NHS Long Term Plan*, and to support areas in which NHS England and NHS Improvement are taking forward major programmes of work or areas identified as priorities for improvement. In other words, this is not a static landscape. I hope that the noble Baroness will be reassured by this and so will be able to withdraw her amendment.

Baroness Barker (LD): My Lords, I thank noble Lords who have contributed to this debate. I realise that time is at a premium, but it was useful to air these issues. I thank the Minister for his full response, although it was not entirely unexpected.

I do not doubt that NHS England has a number of clinical directors, but the stats speak for themselves: 45% of pregnancies are either unplanned or ambivalent and abortion rates are at their highest level. Whatever we have at the moment is not working. The call for this director came from the Faculty of Sexual and Reproductive Healthcare and RCOG; they are people who know this subject in great detail.

I know that across the NHS there are different initiatives trying to bring a greater understanding of gender in medicine. For example, for NHS England I know that the Government are working with the Royal College of Physicians to try to bring about a greater understanding of gender in medicine in the form of training for medical students. But this area of medicine is one in which information, and particularly digital transformation, is already having a significant impact and could have an even greater impact on outcomes. That in itself is a challenge to practitioners, and NHS practitioners are not always the best at dealing with that sort of challenge to their existing practice. Therefore, there is perhaps a case for refreshing the clinical leadership of NHS England in this respect.

If the stats do not improve, we will definitely have to look at this before too long. I listened to what the Minister said about the two strategies that are coming out and I will look at them with a keen eye. In the meantime, I beg leave to withdraw this amendment.

Amendment 20A withdrawn.

Clause 13: Role of integrated care boards

Amendment 21 not moved.

Clause 13 agreed.

Clause 14: Establishment of integrated care boards

Amendment 22

Moved by ***Baroness Walmsley***

22: Clause 14, page 9, line 10, at end insert "within a period of three months following the publication of the list of initial areas."

Member's explanatory statement

This amendment sets a determinate period for the clinical commissioning group or groups to propose the constitution of the first integrated care board.

Baroness Walmsley (LD): My Lords, I will also speak to Amendments 24 and 53 in my name. Amendments 22 and 24 are probing amendments about the time it should take to set up a new ICS constitution and who should do it if the local CCGs fail to do so. I also support Amendment 23 on the importance of consultation, which is in the name of the noble Baroness, Lady Thornton.

I welcome the short delay to implementation that the Government have announced. However, as the Minister probably knows, I am still dubious about whether the Bill is being brought forward at the right time. The NHS is currently in crisis, the staff are exhausted, many are absent through Covid illness or the need to isolate, and the Army and volunteers are being brought in to help. There is evidence that some of the shadow or non-statutory ICSs are not quite as ready as some noble Lords have suggested. Last year, nearly half of them did not publish board papers as they are supposed to do. This is a strong indication that they have not been holding routine public board meetings or joint committee meetings. They may say that they are not obliged to do so until the Bill is implemented, but NHS England said in a paper in 2019 that ICS partnership boards and joint committees, despite not then being statutory bodies,

"should be required to … Make decisions in public meetings … Minute and make public its discussions and decisions"

and publish board papers in advance of meetings. This followed the Commons Health and Social Care Select Committee recommending that

"we expect ICSs to meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes."

It seems that this has not been happening.

At Second Reading, we heard the noble Lords, Lord Stevens of Birmingham and Lord Adebowale, as well as the Minister, assuring us that the NHS is ready for these changes, has been preparing for them for some time and, indeed, has been behaving as far as possible as if these statutory powers and duties to collaborate were already in place as shadow authorities. The passing of legislation, we heard, was just a small barrier to getting on with things. We are being asked to rubber-stamp the way they have done it, despite the amendments that many noble Lords have laid to ensure that people with the right skills and experience to achieve the ICSs' mandatory objectives are appointed to the boards. I think that the noble Lord, Lord Hunt of Kings Heath, will have more to say about that.

What we do not want is a postcode lottery where some areas, which are already well on the way to getting their ICS running smoothly, are getting on with it, while other areas—perhaps those that have been particularly badly stretched during the pandemic and had their attention elsewhere—find themselves with gaping holes in their commissioning for an unacceptable period or even with the wrong people on the board.

That is why I have suggested in Amendment 22 that the relevant CCGs must set up the constitution of their ICS within three months of the passage of the Bill, which would give them time to appoint additional people to the board if your Lordships' arguments persuade them, and the Government, that they need additional skill sets. In Amendment 24, NHS England can do it within the same period if the CCGs do not. The Bill says "within a reasonable time" but, if what I am being told about all the detailed preparation is correct, three months is a perfectly reasonable time.

Amendment 53, my other amendment in this group, refers to new Section 3A in Clause 16:

"Power of integrated care boards to commission certain health services."

It changes the word "may" in subsection (1), which is about securing improvement, to the word "must". It is a simple amendment, but it is fundamental to legislation that seeks to improve the way in which health and care services are provided through integration and collaboration. New Section 3A requires the ICB to commission services to improve its population's physical and mental health and the prevention, diagnosis and treatment of their physical and mental ill health.

1 pm

Why then, if all this welcome stuff is being specified, should we not mandate such improvement? Surely that is the whole point of the legislation. It is not just to make life easier for health and care staff by removing what have been called the clunky legislative barriers to integration. We are doing this to improve the services to patients themselves.

If the Minister accepts this amendment, it will not be the first time a Government have accepted a "may" to "must" amendment from me. Many years ago, it was accepted that the Children's Commissioner for England must have regard to the UN Convention on the Rights of the Child. That mandatory duty has been welcomed by all Children's Commissioners ever since, and they have not found it a burden. Indeed, it has given them an important framework for their work. I was able to convince the Government then that they had already committed themselves to having regard to the convention when they signed up to it years earlier, and that in setting up the duties of this new champion for children it was quite appropriate to restate the commitment that this new public servant should have the same duty, as it was central to her work.

I hope the Minister will see the parallel here: a mandatory duty to improve is exactly what the Government want, and have committed themselves to by laying the Bill before Parliament. Therefore, it should be made clear in the statute. I beg to move.

Lord Hunt of Kings Heath (Lab): My Lords, the noble Baroness, Lady Walmsley, brought us very persuasively to the point of Clause 14, which I must say I am extremely puzzled about, because it purports to set out the whole set of arrangements that have to be gone through before integrated care boards can be set up as statutory bodies. However, it appears that that has already been done.

I register a very strong protest with the Minister at the actions of NHS England in going ahead and establishing these bodies, issuing extraordinary edicts such as no local authority councillor being able to serve on an ICB. What right does a quango have to say that local authority councillors cannot be represented on ICBs? This is absolute abuse of parliamentary power, because quangos do not have the right to set out what should happen on governance issues at local level in the NHS without parliamentary endorsement.

NHS England has put out a note that says that, subject to parliamentary progress, arrangements for the new statutory bodies are to come in now, on 1 July. How can that be, when we have not even gone through the sections that deal with the composition of integrated care boards? It is quite possible that your Lordships might insist on Report that local authority councillors are members of the ICBs. That is not impossible, so what will happen? Will the Minister say that, despite what Parliament says, the ICBs will go ahead, or does it mean, as I read this legislation, that the Government have to start again?

Lots of issues will be raised in this and the next group, not least the outrageous governance issue, which says that NHS England basically appoints the chair and the chief executive officer is also at its disposal. There is no attempt locally to have a board that elects its own chair or one that is appointed independently; they are essentially place-people put in there by NHS England. These are matters that Parliament should decide. I accept that Parliament may say that it is happy to go ahead on that basis—but I strongly object to this clause. It is dishonest; it purports to go through a process from the start that says that this is how ICBs

[Lord Hunt of Kings Heath]
will be set up—but they have all been set up, the boundaries settled and the chairs nominated, without any proper public accountability process whatever.

I hope that, when we come to agree Clause 14, the Minister will think again and that he will issue instructions to NHS England to withdraw the letter that says that the new arrangements will come into place on 1 July. I do not understand how that can possibly be.

Lord Davies of Brixton (Lab): My Lords, I speak to my Amendment 45. This is a disparate group of amendments, dealing with the issue of integrated care boards. I strongly support the comments already made. My amendment addresses another issue. There are questions about what the boards are; the issue is for whom they provide services, and how they are defined.

I have been made aware of a case that raises real questions about how this is going to develop. The case was reported in September, in the *Manchester Evening News*, about a woman who suffered burns while on holiday. She returned to her local urgent care centre in Rochdale and was advised that, because of long waiting times, she should go to another A&E in Bury. When she arrived there, she was told that that centre did not treat people from Rochdale, because of rules laid down by the integrated care board predecessor, which had established the rules in that part of Lancashire. She was left literally on the pavement, unable to obtain the care that she required.

That is a specific case under the existing rules, but it points out the lack of clarity in the Bill about how the integrated care boards will operate. The fear is that they will be membership bodies along the lines of health management organisations in the United States, which are responsible for providing services to members. That contrasts with the residential basis on which the NHS was based, at least up to 2012.

Proposed new Section 14Z31(4) gives the Secretary of State astounding power to set out which ICB is responsible for a particular individual's care. I hope that the Minister will be able to provide some reassurance, but the problem with membership-based organisations is that, first, there will be cherry picking of patients and, somewhat counterintuitively, at the same time they will be competing for the less expensive patients. Without far more clarity through the Bill from the Minister, people will have reasonable fears over how these new organisations will work and how people will attain the services that they currently expect from a seamless provision of services. My amendment seeks to address the issue of it being a single service. We have these 43 ICBs, or whatever they are, but it is a single service, and patients can access services wherever it is best for them and not best for the service.

Lord Scriven (LD): My Lords, I echo the comments from the noble Lord, Lord Hunt of Kings Heath.

We are living in a parallel universe. We are discussing the legislative framework for this new system while, out in the real world, the foundations and the bricks are being built. People are in place. Dates are being set. People are being told that they cannot be on boards. This Parliament has not decided. Under what legislative framework are these organisations working? They have no legitimate powers or approval from Parliament, yet they are being set up. People are being put in place. Chairs are being appointed. Councillors are being told that they cannot sit on ICBs.

This Parliament has not decided that yet. Letters are going out from NHS England telling the system when it will start, and Parliament has not gone through the legislative process. This is not collaborative working at a local level, because many local authorities feel that they are not even in the car let alone in the driving seat; the car is leaving and they are being asked to join at a later date. This is not a good start for collaborative working. It has to stop. NHS England has to be reined in and told that, until there is a legislative framework, the system must stay still.

In that sense, I support Amendment 23, because, significantly, it would give local authorities powers to determine their own destinies. As a former NHS manager, I am not somebody who says that this is a bunch of bureaucrats who are a waste of time. I understand the importance of NHS leaders and managers, but they cannot start drawing lines on a map and ignore local authorities' democratic mandate. This system is not just about administrative convenience; there are real questions about the identity of local authorities, which have built regional boundaries.

Some local authorities look two ways. Let me give noble Lords an example, not a health example but something that happened in south Yorkshire and in which I was involved. The people and the authority of Barnsley, on the edge of south Yorkshire, look to west Yorkshire as well as looking to, and being administratively in, south Yorkshire. As I am sure the noble Baroness, Lady Bennett of Manor Castle, will know, because she knows the local area, when we set up the economic framework it caused a lot of distrust and bad blood for four years, simply because the local authority was not allowed to use the democratic mandate that it had been given and people from the centre were pushing how local economic partnerships and mayoral authorities should be set up.

If we are talking about local authorities and the National Health Service working in a collaborative way, the democratic right of local authorities must be taken into consideration. They know the nuances of their local people in a way that NHS managers do not. I say that having been an NHS manager, a councillor and a leader of a council. It is important to establish the democratic mandate in the system right from the beginning. I can tell you now that if you get a system where two local authorities out of four are forced into an area that they do not want to be in, I can tell you now that it will not work. There will be years of fighting and distrust. This is not just a plea; this is really important. The system has to stop. It has to be a collaborative approach in which local authorities' elected mandate is key, but NHS England must also take its foot off the brake and wait until this Parliament has set the legislative framework before the system gets going. This is a parallel universe and it has to stop.

1.15 pm

Baroness Pitkeathley (Lab): My Lords, I share the outrage of my noble friends and the noble Lord, Lord Scriven, about how this is proceeding. In a way, I

can see how some of this has come about. Perhaps the Minister will say that the Government are building on what is happening on the ground. It is perfectly true that many organisations at a local level found their way around the disaster that was the 2012 Act. They set up systems so that they did not have to follow it and could collaborate and not compete. Many of those systems operate practically on the ground, but they do not operate in a proper legislative framework, as we have heard, and nowhere is that more important than the outrageous decision in some areas to preclude local authorities, as noble Lords have said.

For those of us who know our way around the system, it is easy to ignore the fact that most patients and users—after all, the Bill is supposed to be focused on their experience and what their outcomes will be—have no idea about the difference between local authorities and the local health producers. To them, it is all the council or the NHS, and they have no idea that the GP, the district nurse, the care provider and the local care home do not talk to one another or have any mechanism for coming together. That is the kind of mechanism that we are trying to establish. We must ignore the informal arrangements that may have taken place as a result of the 2012 Act, and establish the proper legislative framework in which all those who have the interests of patients and users at heart are properly represented.

Baroness Bennett of Manor Castle (GP): My Lords, I declare my position as a vice-president of the LGA and the NALC. I will speak particularly to Amendment 23 in the name of the noble Baroness, Lady Thornton, to which I have attached my name; it is unfortunate that we have not heard from her yet. It is about consultation with local authorities, which is what so much of our debate on this group thus far has already addressed. I particularly associate myself with the comments of the noble Lords, Lord Hunt and Lord Davies. A great rearrangement of the NHS has happened entirely under the radar, and it is deeply disturbing to those of us concerned about the risk of the Americanisation of our NHS and its takeover by private US healthcare for-profit companies.

I am slightly surprised that no one has yet mentioned the report in the *Times* this morning about the Health Secretary seeking to model NHS hospitals on academy schools, which has been seen as a large privatisation of our education system. Also, we found out only recently and entirely by accident that the Chancellor was giving days of his time to visit US healthcare companies in California. When you look at those facts, the runes seem very disturbing. To defend against the incidents that the noble Lord, Lord Davies, referred to, and the restructuring by stealth, we need local authority involvement. That is what Amendment 23 seeks to ensure, at least in part.

I also want to comment briefly on another amendment in the name of the noble Baroness, Lady Thornton, Amendment 44, which is about protecting the collective arrangements for pay and conditions for staff. We have to look at it in the context of the survey this week that showed one in four doctors saying that they were exhausted to the point of being impaired in their work. We have an exhausted, utterly worn-down workforce, and we have nurses who are not paid enough and end up going into food banks to feed their families.

It is obviously a matter of justice that we at least protect, and in fact improve, the pay and conditions of healthcare workers. But more than that, it is very much an issue of health as well, because workers who are overworked and underpaid are simply unable to deliver the quality of care that we would hope to provide.

I very much hope that this group of amendments will get some attention, because this has all happened under the radar. There has been no public discussion of this and that desperately needs to happen, so once again it seems to fall to your Lordships' House to try to get this on the agenda.

Baroness Thornton (Lab): My Lords, I will speak to the amendments to Clause 14, which is a very important clause. There is absolutely no doubt about that, and the Minister can be in no doubt that that is exactly how we see it. It was touch and go whether we would have a clause stand part debate on this, and I am not sure that we were right not to do so, because this debate, particularly my noble friend Lord Hunt's comments, has highlighted some serious problems.

My noble friend Lady Pitkeathley is quite right that the arrangements that we are seeking to put into statute, which have grown up over the last few years to allow areas to collaborate, were the right thing to do. In my area of the world, I have no doubt that it was important that the boroughs collaborated together, particularly in their relationship with and commissioning of services from the very big providers.

The question in Clause 14 is: what is going on with the arrangements that the Government are putting into statute? I am very pleased to follow the noble Baroness, Lady Walmsley, and to speak to Amendments 23 and 44 in my name. Amendment 23 addresses the vexed issue of boundaries for an ICB. In this Bill we are dealing with geography, whereas the 2012 Act dealt with GP lists. The area of an ICB is defined in terms of tier 1 local authorities.

Concerns have been expressed, because the NHS is often a bit clueless and sometimes very defensive about local government, its boundaries and its powers. Maybe the Minister will tell me I am wrong, but I suspect that one of the reasons why elected members have been precluded from the boards is that the NHS does not feel comfortable with the direct democratic accountability at that level. That is a great shame. I think it is wrong; accountability is extremely important.

How can we have an integrated service when social care is provided by local government, which is democratically accountable, and we want to integrate that with the NHS at a local level in an area to provide the best service that we can for that population and those patients? The almost offensive way of constructing a board that does not allow elected representatives is not acceptable.

My quite modest amendment seeks to change that situation for the future. There were exchanges in the Commons about this, and there have been meetings with disgruntled authorities that seem to have ended without agreement. We may need to take a step back

[Baroness Thornton]
and learn some of the lessons, perhaps from Scotland and Wales where more logical boundaries have been applied for their health boards.

We may learn a bit more about plans for integrated commissioning at this level when we get the promised but overdue White Paper on integration. It is possible that it will set up a third set of geographies, and who knows how that will line up? This seems to be the wrong way around. Our amendments at least elevate the need to consult with local authorities over boundaries to start off with. That is perhaps a pious hope, but we can agree that any future changes can be made only if the local authorities agree.

Amendment 159 arises out of lengthy discussions elsewhere. In the twin-striker model for ICS, we have the ICBs and the ICPs. We know almost nothing about ICPs; all that is said is that it is part of the "flexibility" and so should be valued. Referring back to my previous remarks, I just hope that local authorities will be genuinely involved in the ongoing discussions about ICPs, how they are set up and their governance. What we do know is that the ICPs will own the analysis of needs and the strategy that follows from that. What, therefore, is the role of local health and well-being boards?

There are echoes of 2012 here, as, during the consideration of the 2012 Bill, amendments were advanced on the same issue. In the 2012 version, it was the health and well-being boards that did the strategy and the CCGs that did the commissioning, at least of health. Nobody ever properly addressed how social care would be commissioned in any integrated way in a wider strategy. It was proposed in 2012 that the health and well-being boards had to approve the plans of the CCGs, and that was the glue that would hold the whole thing together. We know that that has not worked. It has sometimes worked on paper, but it is not the thing that has driven the work of the CCGs.

The answer so far for 2022 is that everyone will play nicely and it will all be resolved. I do not think that can possibly be the case when there is such a serious imbalance. Our Amendment 159 acknowledges that there just might be a dispute over whether some decision or plan of an ICB was genuinely aligned to the strategy that it was supposed to be following, so a process for resolution is needed.

I am not sure whether Amendment 44 sits easily in this group, but it is a matter on which assurance is needed. When foundation trusts came into being, they were rather bravely given the power to set their own terms and conditions for staff. One of them might have tried it, and it was not a great success. In general, despite whatever powers exist, almost every part of the NHS follows the *Agenda for Change*, the collective agreement that took 10 years to agree but which has stood the tests of time.

Now, as with CCGs, we have the power of ICBs to set their own terms and conditions. They are probably unlikely to do so, as it takes an enormous amount of work and the risks that it brings are probably not worth the effort. Without doubt, some staff are worried that they just might be the ones picked on for special treatment. The Minister will no doubt say that the ICBs need the flexibility, but surely, given the pandemic and everything else that faces the NHS, it would be much better to give staff certainty and confidence they will be treated properly.

We agree with the sentiments of Amendments 22 and 24, which try to ensure that agreement on ICB constitutions will be done promptly. We agree with the sentiments of Amendment 53, which echoes a previous amendment about the need to drive improvement. In my noble friend's Amendment 45, he asks a legitimate question, which I think the Minister will need to answer.

Lord Kamall (Con): Once again, I thank all noble Lords for bringing this debate before the Committee today. There have been a wide range of views on the establishment of the ICSs and on what is currently going on in the NHS.

I will start with Amendments 22 and 24 from the noble Baroness, Lady Walmsley, which were supported very strongly by the noble Lord, Lord Hunt of King's Heath, and on the ICBs' establishment. I am grateful to the noble Baroness, Lady Walmsley, for bringing the amendments, and I understand her concerns about ensuring that ICBs are established in a timely way. We agree. We have had an interesting debate here. A number of people have said that it is really important, given that ICSs have already been established, that you put it on a statutory footing, but we are also being asked how they dare to go ahead and do this, because the legislation is not there yet.

In recognition of the fact that ICSs have been set up in some areas and are being established, we are trying to get the right balance. That is why work is under way to prepare existing organisations, including CCGs, for the transition once the Bill comes into force.

The noble Lord, Lord Hunt of Kings Heath, rightly asked whether NHS England is pre-empting Parliament. He raises an important point but I assure him that the powers necessary for establishing each ICB and publishing any statutory guidance cannot be made until the Bill has been enacted and the relevant provisions commenced. However, to ensure that ICBs are ready to begin work, NHS England is producing a range of draft guidance, including a model constitution, so that system partners can start work on preparations—but this does not have the power of statutory guidance. The guidance and the model constitution are based on the proposed requirements—

1.30 pm

Lord Hunt of Kings Heath (Lab): My Lords, I accept that but how can NHS England give guidance to say that no local authority councillor can be on the ICB? That is not for NHS England to say, and how can it do it prior to the Bill going through Parliament? It is for Parliament to decide these matters, not a quango.

Lord Kamall (Con): I apologise to the noble Lord because I was coming to answer that point, but maybe in too long-winded a way. One issue that was clearly raised, and very strongly felt in the contributions from more than one noble Lord, was about banning councillors from sitting on boards. There is nothing in the Bill that

expressly bans this. We recognise the points raised in this debate and will raise them directly with NHS England. It is not statutory guidance.

Lord Hunt of Kings Heath (Lab): I am sorry but this is a very important point. They have made the appointments and are not going to start again, which of course they should, because this is an absolutely hopeless position. No one from NHS England has ever had the guts to come here to explain why they are making this decision, and who will believe it? The chair of the ICB is appointed by NHS England. They know that NHS England does not want local authority councillors on the boards. Who are they going to take notice of? They are going to take notice of NHS England. The Minister has to tell NHS England to stop sending out this ludicrous guidance and telling the NHS that the new arrangements will start from 1 July. It cannot possibly do so if we go through what is contained in Clause 14.

I sympathise with the noble Baroness, Lady Walmsley, but the fact is that we must have a three-month consultation process on the proposals. This is the problem we are in: none of this stands up because Parliament is being treated with absolute contempt by NHS England.

Lord Kamall (Con): I hear the strength of feeling from the noble Lord. I will take this back to the department and discuss it with my right honourable friend the Secretary of State. I hope noble Lords are reassured by that. I may not get the perfect answer, but I will try. I understand the strength of feeling on this issue; no one can fail to do so. Let us put it this way: it was not subtle but direct. It is really important that, as the Minister here, I take this back and reflect the feeling of the House in my conversations with the Secretary of State, and his subsequent conversations with NHS England. I will take that back and look at the consultation process and the CCGs consulting all the relevant local authorities.

I understand the point made strongly by the noble Lord, Lord Scriven, that we have to be careful about prescribing in a top-down way how to work locally. I have always been a strong believer in localism and making sure that powers go down to a local level rather than being taken away. Let me again assure the noble Lords, Lord Scriven and Lord Hunt, and other noble Lords that I will take this back, because clearly there is concern. I had not appreciated the strength of that concern. At Second Reading the noble Lords, Lord Stevens and Lord Adebowale, said, "We are already doing this. It makes sense to go ahead and put it on a statutory footing". But I have now heard the other side of the argument, and it suggests that I should go back and have a stronger conversation with, in effect, my boss—my right honourable friend the Secretary of State. I hope that gives some reassurance.

On Amendment 44, in the name of the noble Baroness, Lady Thornton, I assure your Lordships that we intend to provide as much stability of employment as possible while ICBs develop their new roles and functions. I hope that noble Lords are aware that there is already an existing commitment that staff transferring into ICBs will transfer across on their current terms and conditions in line with the *NHS Terms and Conditions of Service Handbook*. NHS pension rights will also be preserved. As a result, staff transferring into ICBs will not see any change to their existing conditions.

However, the Government are concerned about forcing ICBs to adopt conditions and practices that the ICBs do not believe work best for new staff. We believe that it is important to give ICBs flexibilities relating to staff terms and conditions; they are there for a reason. For example, when it is difficult to recruit and staff are going elsewhere, this would include allowing ICBs the flexibility to diverge from collectively agreed pay scales in order to attract staff from elsewhere or with unusual or valuable skills, or to reflect local circumstances. It will also give ICBs the flexibility to support joint working and bring in staff currently working in local authorities or foundation trusts, for example, supporting integration and the joint working approach that the Bill hopes to encourage.

I also note that ICBs having the independence and flexibility to choose whether to adopt collectively agreed pay conditions and pensions for new staff is not unique, as the noble Baroness, Lady Thornton, acknowledged. NHS foundation trusts, which are already free to exercise their discretion in adopting such conditions, overwhelmingly choose to honour and apply such terms to their staff unless there are good reasons to diverge.

On the proposals for very senior managers, existing procedures are in place to ensure that the most senior staff within the NHS are appointed with fair and equitable salaries. Proposals to pay very senior staff more than £150,000 must be similar to those for other equivalent roles or be subject to ministerial oversight.

The Government are in the process of finalising the procedures that will apply for ICBs. The specifics may differ but the effect and intention will be the same: to afford ICBs agency in setting pay at competitive rates so that we can continue to attract the most senior and experienced leaders, while putting adequate checks and balances in place to ensure appropriate use of taxpayers' money and keep senior public sector salaries at an appropriate level. The Government believe that this amendment, which also asks for ICPs to approve annual salaries in excess of £161,000, is unnecessary. I am happy to have further conversations.

I now turn to the amendments on how the ICBs will function once established, starting with that in the name of the noble Lord, Lord Davies of Brixton, which relates to the question of treatment outside the ICB area. The new clause in question provides that NHS England must publish rules for determining the people for whom integrated care boards have responsibility. Importantly, this clause ensures that everyone in England is covered by an ICB.

We intend that the rules set by NHS England should replicate the current system for CCGs as closely as possible. This means that the ICB will be responsible for everyone who is provided with NHS primary medical services in the area—for example, anyone registered with a GP. It will also be responsible for those who are usually a resident in England and live in their area if they are not provided with NHS primary medical services in the area of another ICB.

[Lord Kamall]

It is important to remember that no one will be denied healthcare on the basis of where they live. We want to ensure that, under the new model, bodies that arrange NHS services—decision-making bodies—are required to protect, promote and facilitate the right of patients to make choices with respect to services or treatment. This means allowing patients to choose to be treated outside their ICB area. Choice is a long-standing right in the NHS and has been working well for some time. The Bill continues to protect and promote it. However, I am afraid that we have concerns about this amendment, as it places a requirement on providers rather than commissioners. It would not be reasonable to expect providers to provide services regardless of whether they were funded by an ICB to do so, and it is important that ICBs should be able to make decisions about with whom they contract and where they prioritise their resources.

On Amendment 53, in the name of the noble Baroness, Lady Walmsley, I hope I can assure the Committee that the Government are committed to ensuring continuous improvement in the quality of services provided to the public. As your Lordships will be aware, there is already a wider range of duties in relation to the continuous improvement of services. Clause 20 imposes on ICBs a duty as to the improvement in quality of services. Furthermore, the ICB must set out how it proposes to discharge that duty at the start of each year in its joint forward plan and explain how it discharged the duty at the end of each year in its annual report. I hope this goes some way to meeting the noble Baroness's concerns.

Clause 16, which this amendment seeks to alter, recreates for ICBs the commissioning duties and powers currently conferred on CCGs in the NHS Act 2006. It ensures that ICBs have a legal duty to commission healthcare services for their population groups. It also recreates Section 3A of the 2006 Act, which provides the commissioning body with an additional power to commission supplementary healthcare services in addition to the services they are already required to commission. This power enables ICBs to arrange for the provision of discretionary services that may be appropriate to secure improvements in the health of the people for whom it is responsible—or improvements in the prevention, diagnosis and treatment of illness in those persons—so it is important that the clause remains as it is currently drafted.

The Bill will ensure that the existing local commissioning duties conferred by the NHS Act 2006 will transfer over to ICBs. This is set out in proposed new Section 3, which is also to be inserted by Clause 16 on page 13. I hope that the noble Baroness, Lady Walmsley, will be reassured that it rightly uses "must" rather than "may" when referring to the arranging of services. I can therefore assure the Committee that ICBs will continue to commission the services previously delivered by CCGs. That will ensure that service delivery for patients is not impacted.

Amendment 159 in the name of the noble Baroness, Lady Wheeler, touches on the important relationship between ICBs and ICPs. I remember that, when we had an earlier consultation, the Bill team had a diagram about how ICBs and ICPs would work together; It might be helpful if I ask for that to be sent to noble Lords so that all of us can have more informed conversations about the intentions of the amendments and the issues that noble Lords want to raise. I will make sure that that is done.

This amendment would add a requirement for the Secretary of State to make regulations to establish a dispute resolution procedure if an ICB fails to have regard to an assessment of needs, an integrated care strategy or a joint local health and well-being strategy in respect of the ICB's area. The Bill was introduced to ensure that existing collaboration and partnership, working across the NHS, local authorities and other partners, is built on and strengthened; I recognise the concerns raised by the noble Lord, Lord Scriven.

We intend for these assessments and strategies to be a central part of the decision-making process of ICBs and local authorities. That is why we are extending an existing duty on ICBs and local authorities to have regard to relevant local assessments and strategies. The ICB and local authorities will be directly involved in the production of these strategies and assessments through their involvement with both the ICP and health and well-being boards at place—that is, at a more geographical level. As a result, they have a clear interest in the smooth working of the ICP.

More widely, there are several mechanisms to ensure that ICBs and local authorities will have regard and not intentionally disregard the assessments and strategies being developed at place in their areas. First, health and well-being boards have the right to be consulted.

Lord Lansley (Con): I just had a flashback moment. I remember being asked, or volunteering, a decade ago to produce a chart of the various organisations under the 2012 Act. I think that the King's Fund did a rather good job of doing it back then; perhaps it might do it again, although it will find that it is more complicated this time.

The noble Baroness, Lady Thornton, asked a perfectly reasonable question that might simplify the process. If health and well-being boards do the same job as integrated care partnerships, in large measure, why cannot integrated care partnerships and health and well-being boards be the same organisation?

Lord Kamall (Con): I remember hearing in an earlier discussion on the Bill that nothing prevents that where they coincide. My noble friend and I have had conversations about health and well-being boards and where they sit. Given that, and given my noble friend's experience of this issue, perhaps we could have a further conversation on this matter before the next stage to clarify some of the issues that he rightly raised in previous conversations.

At this moment, we believe there are mechanisms to ensure that ICBs and local authorities have regard to and do not disregard the assessments of the health and well-being boards. As my noble friend points out, that is for further conversations.

As noble Lords know, NHS England must also consult each health and well-being board on how the ICB has implemented its joint health and well-being strategies, so there is another level of reassurance there. The ICB must also include in its annual report a

review of the steps it has taken to implement any relevant joint local health and well-being strategy and must consult the health and well-being board when undertaking that review. NHS England has formal powers of intervention if an ICB is not complying with its duty in any regard. That is sufficient to ensure that ICBs will have regard to both ICP and health and well-being board plans, but I understand the concerns raised.

1.45 pm

Given the strong collaborative measures in the Bill and the strong foundations of collaboration and partnership working across the NHS—albeit despite the concerns raised by the noble Lords, Lord Hunt of Kings Heath and Lord Scriven—we do not think that further provisions are required. We would expect an ICP to resolve disagreements through discussion and joint working, but there is clearly some concern and I hear the Committee's mood on this.

I hope that we can have further conversations. I will go back to my right honourable friend the Secretary of State for Health to raise the issue about NHS England effectively saying that local councils should not be on these bodies, as well as the other concerns raised about the health and well-being board. With that in mind and further conversations, I hope that noble Lords will feel able not to press their amendments.

Baroness Thornton (Lab): Before the noble Baroness, Lady Walmsley, decides what she wishes to do with this amendment, I say to the Minister that this is very important; I cannot stress this enough. The noble Lord, Lord Lansley, and I are in agreement again about this. At the next stage of the Bill, the Government could find themselves in very serious trouble indeed if we do not resolve it between now and then.

Baroness Walmsley (LD): My Lords, I appear to have opened a can of worms. I very much welcome the Minister's commitment to go back to his boss and talk about some of the serious issues raised by noble Lords.

My purpose in introducing Amendments 22 and 24 was simply to ensure that once the Bill has passed through all its stages in Parliament and an implementation date has been reasonably proposed, from that point onwards there is reasonable coherence across the country so that there are no gaps in the proper commissioning of services and everybody gets on with it in a reasonably timely way.

However, noble Lords will remember that both at Second Reading and when I introduced this group of amendments I expressed my view that it is too soon, for a number of reasons—first of all, the state of the NHS. Also, as has been pointed out by me and other noble Lords, the Bill has not gone through Parliament yet. Last week noble Lords proposed a number of amendments about who should be on the ICB and what skill sets, knowledge and experience should be represented on it. It has become quite clear that, should this House decide to press those amendments, the shadow boards may have to look again at who they have appointed, because Parliament will have said that perhaps they need to appoint some more appropriate people to carry out the objectives that the Government have rightly laid down for them. It became clear to me that the three months I had suggested might not be quite enough, because of the consultation. It would not be the first time that noble Lords had laid amendments that were to some extent faulty but had stimulated an important discussion among other noble Lords.

I very much appreciate the Minister's commitment to going back. I hope that, when he has those conversations, he remembers that noble Lords in this House are very supportive of the objectives of allowing local authorities to play their appropriate part in the establishment and running of these new boards, and allowing health and care people to work collaboratively in the interests of patients.

I want to say a brief word about Amendment 53. The Minister gave me several reassurances about where, in other parts of the Bill, there really is a duty to improve. I am afraid that he succeeded only in convincing me that changing "may" to "must" in the place I suggested in the Bill is totally consistent with what he says exists in other places, so I may come back to that at later stages.

Noble Lords will have their say about who should be on these ICBs. Things may have to change and appropriate time may need to be allowed for the now-appointed chairs of all the ICBs to make some corrective measures regarding who they have on their boards. I will leave all those thoughts with the Minister. For the moment, I would like to withdraw my amendment.

Amendment 22 withdrawn.

Amendments 23 and 24 not moved.

Baroness Chisholm of Owlpen (Con): My Lords, we will start the next grouping now but we will stop at 2.15 pm. Anybody who is speaking three minutes before 2.15 pm should realise that they will have only three minutes before we stop, if the Committee sees what I mean.

Amendment 25

Moved by ***Lord Hunt of Kings Heath***

25: Clause 14, page 11, line 20, at end insert—

" NHS Appointments Commission

(1) There is to be a body corporate known as the NHS Appointments Commission.

(2) The NHS Appointments Commission has the function of—

(a) appointing the Chair and ordinary members of integrated care boards;

(b) other duties as set out in regulations under subsection (3).

(3) The Secretary of State must by regulations provide for—

(a) the establishment and constitution of the board of the Commission;

(b) the financing of the Commission;

(c) the duties of the Commission.

(4) The Commission must prepare and submit an annual report of its activities to Parliament."

Member's explanatory statement

The amendment would provide for an independent commission to have responsibility for the appointment of the chair and ordinary members of integrated care boards.

Lord Hunt of Kings Heath (Lab): My Lords, in moving Amendment 25, I will speak to other amendments in this group, which follows on from the previous group and the last comments made by the noble Baroness, Lady Walmsley. On day two in Committee, we had an interesting discussion about the composition of integrated care boards. My noble friend Lady Thornton and other noble Lords argued for specifying in some detail the composition of ICBs, including having representation from mental health trusts, public health, staff and the patient's voice.

Equally, the noble Lord, Lord Mawson, discussed the problems that arise when members on committees are seen to represent what he called "other agendas". The noble Baroness, Lady Harding, was supportive of that view, although she argued that

"we should think more about what we want the integrated care boards to do".—[*Official Report*, 13/1/22; col. 1303.]

and how we will measure this, rather than exactly who is on them. I see the force of that argument; I for one am pretty uncertain about what exactly these integrated care boards are all about.

The noble Lord, Lord Hunt of Wirral, went to the heart of this when he raised an issue that has troubled me right from the beginning: the provision that NHS trusts and foundation trusts are to be members of the integrated care boards. As he said:

"Organisations that provide the bulk of NHS services"

are therefore brought into the work of commissioning. The current system is one where commissioners—CCGs—hold providers to account

"objectively determining whether they are best placed to provide a service and assessing their performance"

and, as he said, the question then arises as to how the new integrated care boards can

"continue to perform that role."

He felt that the membership of provider appointees on those boards at least created a risk of

"a conflict of interest between the roles of those individuals on the board and any roles they may hold with provider organisations".—[*Official Report*, 13/1/22; col. 1297.]

In response, the Minister said that

"each ICB must make arrangements on managing the conflict of interest and potential conflicts of interest, such that they do not and do not appear to affect the integrity of the board's decision-making processes. Furthermore"—

this is a very relevant point—

"each appointee to the ICB is expected to act in the interests of the ICB. They are not delegates of their organisations, but are there to contribute their experience and expertise for the effective running of the ICB".—[*Official Report*, 13/1/22; col. 1308.]

Up to a point, Lord Copper. I am now totally confused as to what ICBs are. I must admit that I thought that reason for having all the key local players around the table was to brokerage deals, sort out the flows of money and keep the show on the road, but the Minister's vision seems to be for a rather more rarefied forum, where members of the ICBs have to leave their interests behind them and think Olympian thoughts in the interests of the greater good. However, when you think of an ICB, with members of a major trust sitting around the table, and local authorities represented not by their political leadership but by officers, how on earth can they leave their principal interests behind them? Surely the responsibility of the CEO of a trust or presumably of a local authority or the director of adult social care is to represent the interests of the organisations on that board.

I will give a couple of examples. On page 21, the Bill states in relation to new Section 14Z50 on the joint forward plans for an integrated care board and its partners that

"an integrated care board and its partner NHS trusts and NHS foundation trusts must prepare a plan setting out how they propose to exercise their functions in the next five years."

That is fine, because that is probably one of the most important things that they have to do, but what are the trusts' chief executives on the ICB expected to do? Are they expected to sit there and declare that it is a conflict of interests and therefore take no part in the discussion, or are they there to represent the interests of their trust, because the forward plan is very important to the success or otherwise of their organisation? It would be the same with the local authority representative, even though that representative, because they are an officer, will have to report back all the time to their political leaders to get the green light to what they have to agree to within the ICB board, which is why it is so stupid to keep local authority councillors off that board.

The Minister says, "Oh well, if it all goes wrong, we can use regulation powers to put it right". But we are at the beginning of this process, and we need to get it right now. I very much ask the Minister to think again about the structure of ICBs and how on earth you can expect them to operate if the large trusts that they are supposed to commission serve round the table. It is really a nonsense in governance terms. Only NHS managers could have come up with this—and, oh dear, it was NHS managers who came up with it. Much though I love them and have represented their interests, I agree with the noble Lord, Lord Scriven, that accountability and democracy do not come very easily to them, and you can see that in the complete mess that we see before us today.

We then come to the question of whether these ICBs are accountable at all locally. I see no evidence of that at all; they are clearly part of a top-down managed hierarchy. How can you explain the reasons for the chair being appointed by NHS England and not by the board itself? How can the chair be removed from office only by NHS England? The chair should hold office at the confidence of the board. It should be the board that decides whether the chair is competent to continue, subject to external regulatory interventions, as of now, where that is necessary.

Secondly, why does the appointment of the ICB members have to be approved by the ICB chair? I am sorry that the noble Lord, Lord Scriven, is not here. If I, as leader of Birmingham City Council, for instance, decided that my director of adult social care should go on to the board of the Birmingham and Solihull ICB, what right does the chair have to give their approval or not to that appointment?

We have already discussed the nonsense of local authority councillors being left off, but let me just make one other point. If you were the chief executive of the local authority appointed to an ICB, where you are making big decisions about finance, does the Minister imagine that that officer will do it off their own bat, or

does he think that every step of the way they will report back to the leader of the council and the cabinet member for social care? Of course they will.

The problem is that NHS managers think local government is run in the way the NHS is run; they think the officers are in charge. But they are not, because you have political, democratic leadership. It is the same with Ministers in government, which it seems is why they have got themselves into such a mess in relation to this governance.

2 pm

The ICB does not even appoint its own chief executive officer. The CEO is appointed by the chair, with the approval of our old friends NHS England. Again, why? Surely, the chief executive should be appointed by the board of the ICB through a proper appointments process. What we can see is, first, that these ICBs will basically be the tools of NHS England, because the chair and the chief executive officer owe their continued existence to that quango. Secondly, we see that they have built a huge conflict of interest into the structure.

When taking evidence last year, the Health and Care Select Committee concluded that it was

"vital that local populations have confidence in the boards of the NHS Body … and transparency in the appointment process for those boards will be a key factor".

I agree. The argument I put forward, particularly in my first amendment, is that there must be some independent process or scrutiny of the appointments of ICBs. When the composition of NHS England was debated on the first day in Committee, the noble Earl, Lord Howe, said he agreed that

"robust governance arrangements are absolutely necessary to oversee public appointments, particularly to NHS England".—[*Official Report*, 11/1/22; col. 987.]

He then qualified it by saying that it did not apply to ICB boards. He was absolutely right, because the one thing they do not have is a robust independent appointments process. I put this point to the Committee: why can we not put a proper appointments process in? Why do we not resurrect an independent NHS Appointments Commission to do the job properly, make sure that the governance arrangements are fit for purpose, and ensure there is much more local confidence in these ICBs and what they are there to do?

The board should appoint the chair; the chair and the board should appoint the chief executive officer. They should stay in those positions at the disposal of the boards, and those members should be appointed through an independent process which should include local authority councillors nominated by the principal local authorities within the ICB board region. ICBs cannot be expected to carry any weight locally, given the way they have been constructed at the moment.

I urge the Government to think again about this. They may want to push on and have it accepted with a fait accompli but, in the end, it is their decision in Parliament as to how these bodies operate. Unless we do this, it is pretty clear that we will be coming back within the next year or two with another NHS restructuring Bill. We have already heard about the ludicrous decision to keep health and well-being boards at the same time as having ICBs. We all know that, looking at it, this structure will not keep. It would be better if the Government started to sort it out now. I beg to move.

Baroness Thornton (Lab): My Lords, I rise only to say that I agree with my noble friend Lord Hunt. I will speak very briefly to Amendment 24 in the name of my noble friend Lady Merron, which would ensure the involvement of the integrated care board and the integrated care partnership in the appointment of the ICB chief executive. That seems to me to be sensible.

Baroness Walmsley (LD): My Lords, I support that. I am glad that the noble Baroness, Lady Thornton, introduced Amendment 34. According to the Bill as it stands, the chief executive of the ICB could be appointed only by the chair—of course with the approval of NHS England. Like many of your Lordships, I have been on a board, including being the chair of a board, and as such, I always thought it good practice to appoint my chief executive with the help and approval of my board members. As an ordinary member of a board, I cannot imagine how I would have managed the relationship with a chief executive officer who had been appointed over my head only by the chair without any consultation with me or other members. If we want to encourage collaboration, that is not the way to do it at board level.

It is inconceivable that the mechanism would work in practice in such a situation. Indeed, it is vital that all the senior people who steer the ICS, the members of the ICB, and indeed the chair and members of the ICP, must have confidence in the chief executive; the word "confidence" was so appropriately used by the noble Lord, Lord Hunt of Kings Heath. How could that be if they had no involvement whatever in the appointment? It is a simple matter of good practice and I shall be very interested to hear what the Minister can possibly find to say against it.

Baroness Chisholm of Owlpen (Con): My Lords, I know we have 10 minutes to go, but perhaps it makes sense to stop now in case noble Lords want to interject during the Minister's speech.

Debate on Amendment 25 adjourned. House resumed.

2.06 pm

Sitting suspended

EU-UK Partnership Council

Question

2.30 pm

Asked by ***Baroness Hayter of Kentish Town***

To ask Her Majesty's Government what will be on the agenda for the next meeting of the EU-UK Partnership Council, and when will that meeting take place.

The Minister of State, Department for the Environment, Food and Rural Affairs and Foreign, Commonwealth and Development Office (Lord Goldsmith of Richmond Park) (Con): My Lords, the date for the second meeting of the Partnership Council has yet to be confirmed. The first Partnership Council met on 9 June last year;

[Lord Goldsmith of Richmond Park]
it marked an important milestone in standing up the trade and co-operation agreement governance structures. The agenda for the next meeting will be agreed with our EU counterparts. We will push hard to ensure that priority issues for the UK are discussed and our interests are protected.

Baroness Hayter of Kentish Town (Lab): If this means that the Minister has replaced the noble Lord, Lord Frost, I welcome him to his new position; he is saying, "No fear", so I thank him at least for answering the Question today. As we have passed the authority in both Houses to establish the Parliamentary Partnership Assembly, the membership of which is due to be announced very shortly, can he give us an undertaking that our Foreign Secretary, as co-chair of the Partnership Council, will report both before and after meetings of the council to the newly established Parliamentary Partnership Assembly?

Lord Goldsmith of Richmond Park (Con): I will certainly convey the noble Baroness's message to the Foreign Secretary; I cannot make an undertaking on her behalf, but it certainly seems in the spirit of the approach she has taken of involving both Houses and maximum transparency.

Lord Teverson (LD): My Lords, technically the Parliamentary Partnership Assembly will cover only the trade and co-operation agreement, yet some of the key issues between the UK and the EU are within the withdrawal agreement—not least Northern Ireland and, most importantly to MPs and Members of this House, UK and EU citizens' rights. Will the Government sympathetically support the assembly extending its remit to the withdrawal agreement and those key areas?

Lord Goldsmith of Richmond Park (Con): My Lords, our relationship with the European Union hinges in many respects on issues yet to be resolved. The noble Lord mentioned two of them. Resolving issues around the Northern Ireland border is an absolute priority for the Government; likewise, issues around friction-free visa travel within the European Union and changes to border requirements are high on the agenda. His priorities are very much in sync with those of the Foreign Secretary.

Lord Hannay of Chiswick (CB): My Lords, does the Minister agree that the experience of the first year of operation of this council has shown that the very passive and rather negative approach to it—doing the least possible and having only the one statutory meeting required—has not so far delivered any very useful outcomes? Would it not be better if the new British chair of the council showed a more proactive policy towards it and, when items are to come up on the Partnership Council, started to shape up what decisions that might come out of it would be to our benefit?

Lord Goldsmith of Richmond Park (Con): My Lords, I am not sure I agree that we have taken an insufficiently proactive approach, but I certainly think the new Foreign Secretary has brought a particular level of energy to the task. The first meeting last year saw frank but constructive discussions on the TCA implementation; yes, a number of areas of disagreement were identified, but the process launched the governance and committee structures of the TCA and our commitment to dialogue and co-operation. I think it achieved the first goals that were set out.

Baroness McIntosh of Pickering (Con): My Lords, will my noble friend take this opportunity to update the House on meetings of specialist committees between the UK and the EU, particularly in areas such as fisheries, which are so key to our ongoing and future relationship with the EU in these policy areas?

Lord Goldsmith of Richmond Park (Con): I will try in due course to provide answers relating to other specialist committees, as the noble Baroness mentioned, but on fishing licences our approach has been and remains fully in line with our TCA obligations. We have said throughout the process that we have issued licences where we have received evidence of an entitlement. It is worth pointing out that the UK has issued over 1,800 licences to EU vessels seeking to fish in our waters.

Baroness Chapman of Darlington (Lab): My Lords, at the meeting of the Partnership Council on 9 June, sanitary and phytosanitary measures were discussed. Can the Minister confirm whether the Government intend to seek what is often called a veterinary agreement and whether there is any progress on that?

Lord Goldsmith of Richmond Park (Con): I am not able to give the noble Baroness any kind of detailed update on those discussions. I do not believe there is an update to provide, other than that those discussions continue. If there is more to provide, I will do so in writing.

The Earl of Clancarty (CB): My Lords, on 16 December, in answer to a question from my noble friend Lord Hannay, the noble Lord, Lord Frost, indicated that performing artists would be discussed at the next meeting. Little has been done to resolve the huge concerns of musicians touring in Europe; cabotage, for instance, has to be discussed at the TCA level. Will this be put on the agenda?

Lord Goldsmith of Richmond Park (Con): My Lords, the Government are committed to supporting the music sector to adapt to our new arrangements. We worked with DCMS to speak to EU member states about the importance of touring; 21 of them have confirmed that they offer visa and work permit-free routes for performers and other creative professionals. This includes most of the biggest touring markets, including Spain, France, Germany and the Netherlands.

Baroness Crawley (Lab): My Lords, before we left Euratom, EU representatives used to carry out external checks on the way in which we monitored emissions from UK nuclear sites. That no longer happens. It has not been replaced by another system. Can the Minister say, or find out, when the Partnership Council will discuss our post-Euratom radioactive substances status, an important policy area which intersects, as he will know, with the trade and co-operation agreement?

Lord Goldsmith of Richmond Park (Con): My Lords, much of the work the noble Baroness describes was conducted on the back of UK experience and expertise, neither of which have gone. On the precise relationship we will have with Euratom going forward, those discussions continue but I will see whether I can provide more of an update to her in due course.

Baroness Greengross (CB): My Lords, Paul Johnson of the Institute for Fiscal Studies recently highlighted that trade with the EU has declined sharply since 2019. Based on OBR figures, the prediction is that this reduction in trade post Brexit will reduce productivity in this country by 4%. What action will the Government take to address this? Will they finally admit that the promised benefits of the UK leaving the single market have not been realised?

Lord Goldsmith of Richmond Park (Con): My Lords, a number of factors—not least a Covid lockdown across Europe and businesses adjusting to our new trading relationship—have made inevitable the dip in exports to the EU that the noble Baroness describes. However, the Office for National Statistics has cautioned that it is impossible to identify the underlying causes, at least at this point, and that we should be careful not to extrapolate. In answer to the second part of her question, I say that the Department for International Trade will continue to work with businesses and business groups across all sectors and the whole country to make the export support service work as well as possible for businesses. As we set out in the *2025 UK Border Strategy*, our ambition is to create the most effective border in the world.

Lord Moylan (Con): Will my noble friend use the next meeting of the Partnership Council to point out to the European Union that Northern Ireland is now the only part of Europe in which laws are made for its people without any democratic mandate or input from them and that this situation is incompatible with its own EU Charter of Fundamental Rights?

Lord Goldsmith of Richmond Park (Con): My noble friend makes a hugely important point. I reiterate that our overall aim is to renegotiate the Northern Ireland protocol to resolve the undoubtedly significant issues that people in businesses in Northern Ireland face daily. The EU has recognised that the current arrangements do not work. Any solution must be underpinned by the commitments made in the Good Friday agreement.

Baroness Hoey (Non-Afl): My Lords, how will—

Lord Davies of Brixton (Lab): My Lords, another—

The Lord Privy Seal (Baroness Evans of Bowes Park) (Con): My Lords, we have not yet heard from a non-affiliated Member, so we will do so now.

Baroness Hoey (Non-Afl): My Lords, how will Her Majesty's Government judge the success of this partnership and whether it is worth continuing in the future?

Lord Goldsmith of Richmond Park (Con): My Lords, it is hard to know how effective the partnership is, given that we have only had one of those meetings. We have another meeting at some point this year. It has not been scheduled yet, but we certainly expect it to happen. It would be easier to answer that question on the back of the results of that meeting.

Peat

Question

2.41 pm

Asked by ***Baroness Jones of Moulsecoomb***

To ask Her Majesty's Government what plans they have to undertake further consultation on the professional use of peat.

The Minister of State, Department for the Environment, Food and Rural Affairs and Foreign, Commonwealth and Development Office (Lord Goldsmith of Richmond Park) (Con): My Lords, we are currently consulting on measures to end the use of peat in horticulture in England and Wales. This includes a call for evidence on the impacts of ending the use of peat and peat-containing products in the professional horticulture sector. The consultation closes on 18 March this year. Our assessment of the responses and the evidence that we receive will inform our next steps, which will include targeted engagement with specialised areas within the sector.

Baroness Fookes (Con): My Lords—

Baroness Jones of Moulsecoomb (GP): I was frightened that that would be the Answer. Environmentalists are sick of all these consultations. The Government promised to ban peat in 2020, and there were years to achieve that then. In the interests of moving on, I suggest two things: first, that imports of professional peat be stopped, because when we stop selling it here it will just get imported. Therefore, this is a primary thing to do. Secondly, we must replace peat with something, and we could use green waste from councils, for example. Can the Minister take that back to his department and make them think about it?

Lord Goldsmith of Richmond Park (Con): My Lords, I will certainly take both those suggestions back to the department. The point the noble Baroness makes about imports is a good one; I will have that discussion with the Secretary of State. She is not the only person who is sick of endless consultations but unfortunately, they are unavoidable when the impact of a policy affects the value of a business or of assets. We have no choice but to consult, but we are doing so as quickly as we can.

Baroness Fookes (Con): My Lords, with apologies for jumping in too soon, the main concern of those who use peat professionally is finding alternatives of sufficient quality and quantity. This is not easily solved, even by just using green waste. Can my noble friend ensure that very real research is done by his department into a cure for this problem?

Lord Goldsmith of Richmond Park (Con): My noble friend raises an important point, and she is right that there are insufficient amounts of suitable replacement materials. However, there is clearly scope for making better use of what is otherwise garden and vegetable waste. There are high-quality peat-free alternatives that are effective and price-competitive, including a growing material formulated with wood fibre, bark or coir, all currently available in garden centres.

Lord Clark of Windermere (Lab): My Lords, as the Minister knows, 3% of the earth is covered with peatlands, but they account for a third of the store of carbon. It is imperative that this carbon is not disturbed. We have a huge amount here in the United Kingdom. Can the Government commit to reducing to a minimum the amount of carbon from peat bogs?

Lord Goldsmith of Richmond Park (Con): My Lords, I absolutely make that commitment, and that is one reason why we are moving with renewed vigour on banning the use of peat in horticulture. Additionally, our England peat strategy lays out ambitious plans to restore degraded peatlands on a scale we have not done before in this country, with plans leading up to 2050 involving hundreds of thousands of hectares being repaired, for all the reasons that the noble Lord has identified.

Lord Rogan (UUP): My Lords, the Minister may be aware that DAERA has undertaken a consultation on the peatland strategy for Northern Ireland. While peatlands cover 11% of England's land area, 24.6% of Northern Ireland is covered by peat. Is there scope for Defra to play an active part in the formulation of this strategy to ensure that it delivers the very best results for Northern Ireland and its ecosystem?

Lord Goldsmith of Richmond Park (Con): The peat strategy we have produced is an England peat strategy, so clearly, there are geographical limits. However, the issue goes far beyond England: it is a UK issue, for the reasons the noble Lord has provided. Peatlands are iconic features of our landscape. They are the UK's largest stores of carbon by far, and they provide hugely important ecosystem services, supply over a quarter of the UK's drinking water, decrease flood risk and provide food and shelter for rare and, in some cases, endangered wildlife. That is why peat recovery and peat protection is a priority.

Baroness Ritchie of Downpatrick (Lab): My Lords—

The Lord Privy Seal (Baroness Evans of Bowes Park) (Con): My Lords, it is the turn of the Liberal Democrats. The noble Lord, Lord Jones of Cheltenham, wishes to speak virtually and this is a convenient point to call him.

Lord Jones of Cheltenham (LD) [V]: My Lords, the UK's peatlands are of immeasurable importance, storing three billion tonnes of carbon—as much as the forests of the UK, Germany and France combined. What discussions have the Government had with other countries about stopping the extraction of peat, and was any progress made at the recent COP 26?

Lord Goldsmith of Richmond Park (Con): My Lords, an enormous amount of progress was made at COP 26. The story that made the headlines related to forests but the principles that were agreed around the protection of forests apply also to peatlands. Between us, we secured unprecedented sums—billions of dollars of finance—specifically to protect fragile, carbon-rich, biodiverse-rich ecosystems such as peatlands. Part of the agreement we reached involved commitments by countries with those precious habitats to end their destruction and to engage in restoration with renewed vigour.

Baroness Ritchie of Downpatrick (Lab): My Lords, the Minister has already referred to the need to protect peatlands as an example of our iconic landscapes; they are a feature of these islands. Considering that the devolved Administrations are involved in this work as well, as a follow-on to COP 26 and as a means of protecting our landscapes, can he give due consideration to leading a summit with his ministerial colleagues and those involved in environmental organisations on how to protect our precious peatlands the length and breadth of the United Kingdom?

Lord Goldsmith of Richmond Park (Con): I am very happy to make that commitment on behalf of my colleagues in whose portfolio and remit this issue sits. From an international perspective, the noble Baroness makes a very important point. We are designing programmes on the back of the new commitments we have made using our ODA; £3 billion of our international climate finance commitment will be invested in nature-based solutions, a very big part of which will be peatlands. I hope that we can describe in more detail soon what those projects will involve.

Baroness Jones of Whitchurch (Lab): My Lords, in a Written Answer to me, the Minister stated that all government departments and their arms-length organisations should meet the mandatory government buying standards, which include not purchasing peat. Can he confirm that all government departments are indeed abiding by that ruling, and explain why organisations such as the Forestry Commission are still purchasing and using peat when, as we have heard, other alternatives are available?

Lord Goldsmith of Richmond Park (Con): The noble Baroness is right: Forestry England continues to use peat in the manner she has described. However, it has committed to eliminating completely the use of peat in the growing media by 2028 at the very latest. All government departments and their related organisations must ensure that they meet the minimum mandatory government buying standards when buying goods and services. We also encourage the wider public sector to do likewise, but it is certainly our intention to accelerate the progress that is and being and needs to be made.

Lord Geddes (Con): My Lords, where does peat as a fuel fit into this picture?

Lord Goldsmith of Richmond Park (Con): I am not convinced that peat as a fuel does fit into this picture.

Our priority is to restore peatlands as closely as possible to their natural conditions, so they can fulfil the ecological functions we need them to fulfil.

Lord Teverson (LD): My Lords, I am interested to understand how the Government reconcile allowing commercial peat exploitation while at the same time the Exchequer, and thus taxpayers, are paying millions of pounds for peatland restoration.

Lord Goldsmith of Richmond Park (Con): I am afraid I cannot provide that justification because there is a clear contradiction, but that is why we are pushing ahead with our proposals and measures to eliminate the use of peat in horticulture. The noble Lord makes a very good point.

Baroness McIntosh of Pickering (Con): My Lords, does my noble friend share my concern that, since we have left the European Union, we will now have different environmental standards in England, Wales, Northern Ireland and Scotland? Will he use his good offices to ensure that the devolved nations all impose a ban on the use of peat for horticultural purposes, bearing in mind that it takes 200 years to create a peat bog?

Lord Goldsmith of Richmond Park (Con): My Lords, it is not a source of concern that we are able to legislate or regulate differently; the UK has demonstrated a commitment to raising the bar in terms of environmental protections. It is generally recognised—if not in this country then certainly elsewhere—that the UK is a world leader in conservation and nature restoration, but it is for the devolved Administrations to make their own policies and, of course, we will continue our discussions in the hope that we are as closely aligned as possible.

State Pension Age

Question

2.51 pm

Asked by ***Baroness Bryan of Partick***

To ask Her Majesty's Government what consideration they will give to the latest Office for National Statistics' projections for (1) life expectancy, and (2) healthy life expectancy, when reviewing the state pension age.

The Parliamentary Under-Secretary of State, Foreign, Commonwealth and Development Office and Department for Work and Pensions (Baroness Stedman-Scott) (Con): The department launched the second review on state pension age in December 2021. It must be published by May 2023, in accordance with Section 27 of the Pensions Act 2014. The review will be informed by two independent reports and will consider a wide range of evidence. This will include consideration of the latest Office for National Statistics projections for life expectancy and healthy life expectancy. Tempting though it is, we must wait for the report to come out before we comment.

Baroness Bryan of Partick (Lab): I thank the Minister for that response and the point she makes that the ONS projections seem to confirm that life expectancy is no longer increasing. As it is, the people most dependent on a state pension are more likely to have a shorter life expectancy than those with additional pension provision. Many will die before they reach retirement age or will receive their state pension for only a few years. Does the Minister accept that a fair pension scheme must take account of the life expectancy and healthy life expectancy of people in deprived areas—not just a broad average across the board? Can she assure us that the Government's review of the state pension age will take that into account?

Baroness Stedman-Scott (Con): The noble Baroness makes a number of important points. We want a fair pension system, and her points about life expectancy, particularly in some of the poorer areas of the country, are valid. On the review, I know that my noble friend Lady Neville-Rolfe will want input from Members of this House who are concerned and who have expertise, and I encourage the noble Baroness to make sure that those points are made to my noble friend when she carries out her review.

Lord Lilley (Con): Has my noble friend considered the conclusion of the Office for National Statistics that:

"Over a 20-year period the estimated change in deaths associated with warm or cold temperature was a net decrease of 555,103 … A decrease in deaths from outcomes associated with cold temperature greatly outnumbers deaths associated with warm temperature"?

Is it not good news that climate change has prolonged or saved the lives of more than half a million of our fellow citizens—

Noble Lords: Oh!

Lord Lilley (Con):—a laughable matter to the Liberal Benches over there—and how long does she expect this beneficial effect to continue?

Baroness Stedman-Scott (Con): My noble friend has again given us some interesting facts and data. I am afraid that the impact of climate change is way outside my brief, but I am sure everybody notes the points made.

Lord Davies of Brixton (Lab): My Lords, the Minister quite rightly referred to the ongoing reviews, but I simply ask, as a matter of logic, that, if the policy is that because people are living longer, retirement age should increase, is it not the necessary corollary that if people are not living as long as previously expected, retirement age should not be increased in the same way?

Baroness Stedman-Scott (Con): I will not argue with logic; that would not get me anywhere. On the noble Lord's point about the state pension age, I know that people are sceptical of government reviews, but I ask all noble Lords to approach it in a positive way, make their points—particularly the one raised by the noble Lord—and get them into the review.

Baroness Janke (LD): My Lords, around 1.5 million low-paid workers pay a 25% penalty for their pension savings. When will the Government publish the outcome of their call for evidence on pensions tax

[Baroness Janke]
administration to enable low-paid workers, who are typically women, to receive pensions tax relief on their contributions?

Baroness Stedman-Scott (Con): Many noble Lords have made this point, including the noble Baroness, Lady Drake, and my noble friend Lady Altmann. The truth is that I do not know when they will do it, but I will go back and find out, and will write to the noble Baroness.

Baroness Jenkin of Kennington (Con): My Lords, women are disproportionately affected by pensioner poverty. What are the Government doing to support and help them?

Baroness Stedman-Scott (Con): Since 1994-95, rates of female pensioners in poverty, by all measures, have fallen by a larger amount than rates of male pensioners in poverty over the same period. The proportion of pensioners in absolute poverty, after housing costs, has halved since 2002-03. Pension credit is the safety net—I know that will open the floodgates for a raft of other questions—and we must make sure that as many people as possible apply for that benefit.

Baroness Sherlock (Lab): My Lords, I cannot let that go: relative poverty among pensioners is on the rise again, having fallen considerably for years. However, controversially, I will come back to the Question. The latest ONS tables show that life expectancy at birth in the UK is 79 for men and 83 for women. But life expectancy is lower in Wales and Northern Ireland, and especially Scotland, than it is in England. What are the Government doing to engage with the devolved Administrations, and how might pension policy take account of that?

Baroness Stedman-Scott (Con): I hope that, during the review, the devolved Administrations will be consulted. I will certainly go back to the department and speak to the Secretary of State to make sure that that is included in the review. The review will then report, and the noble Baroness will get the answers that she is looking for.

Baroness Altmann (Con): My Lords, I am delighted that my noble friend Lady Neville-Rolfe will be leading an independent inquiry. Can my noble friend the Minister assure the House that some flexibility in state pension age will be considered for those who are not healthy and wealthy enough to wait for the ever-rising state pension age? With a significant, 20-year difference in healthy life expectancy across the country, perhaps very long national insurance records might be considered for early access to the state pension.

Baroness Stedman-Scott (Con): As I have said many times, I cannot give any guarantees, but I am absolutely sure that the points my noble friend raises about flexibility and age will be included in the review. I urge her to take part in that consultation.

Lord Sikka (Lab): My Lords, poorer people tend to die at a younger age than richer people. Each increase in the state pension age effectively results in a wealth transfer from the poor to the rich, who will receive the pension for many more years. Can the Minister tell the House why the Government have pursued pension policies that penalise the poor and transfer wealth to the rich? Why this reverse socialism for the rich?

Baroness Stedman-Scott (Con): I doubt I will be able to convince the noble Lord, but nobody wants pensioners to be in poverty and nobody wants to run a book on transferring wealth from one place to the other. The noble Lord raises a valid point. I know I am repeating myself, but it is one that I expect will be in the review; knowing how much knowledge the noble Lord has, especially on how to pay for these things, I look for him to have input into the review.

Lord Flight (Con): My Lords, in the last two years, life expectancy has been below the expectancy of the industry. If that continues to be the case, does it mean that slight pension increases could be afforded?

Baroness Stedman-Scott (Con): I imagine that, if things go as my noble friend has just said, that is a possibility, but I am not able to confirm it. Again, I urge my noble friend, who has a raft of experience in this field, to get his point into the review.

Lord Watts (Lab): My Lords—

Baroness Hayman (CB): I am grateful to the noble Lord and declare my interests as set out in the register. Referring to the points made by the noble Lord, Lord Lilley, does the Minister agree that the interaction between health and climate change really warrants a more sophisticated analysis of all the factors involved, rather than the assertions made by the noble Lord in his intervention?

Baroness Stedman-Scott (Con): I can assure the House that my noble friend Lady Neville-Rolfe will pay due attention to the seriousness of the interaction between the points the noble Baroness has raised. I have no doubt that will happen.

Enforcement of Lockdown Regulations

Question

3.02 pm

Asked by ***Baroness Chakrabarti***

To ask Her Majesty's Government what assessment they have made of the equality of treatment between different groups in respect of the enforcement of lockdown regulations by the police since spring 2020.

The Minister of State, Home Office (Baroness Williams of Trafford) (Con): My Lords, we are clear that nobody should ever be subject to police enforcement based on their race, gender, ethnicity, age or any other protected characteristic. That is why the NPCC—the National Police Chiefs' Council—has commissioned an independent analysis of fixed penalty notices issued to different demographic groups during the pandemic. The findings from this analysis will be published in due course.

Baroness Chakrabarti (Lab): I am grateful to the Minister for that, particularly after such a long night. Broad police powers, however well-intended, will inevitably lead to arbitrary and discriminatory enforcement. She makes the point about racial bias and I look forward to the fuller picture. Have the Government now gathered more complete data on differentials in enforcement of lockdown regulations? How much was directed at, say, small family picnics or peaceful protests, as opposed to unsafe places of work?

Baroness Williams of Trafford (Con): As I said to the noble Baroness in my first Answer, there is going to be more analysis of FPNs issued to different demographic groups. The outcome will be very interesting in all sorts of contexts—social and otherwise. Like her, I look forward to the findings from the analysis. In parallel to that, the HAC has published its report, *The Macpherson Report: Twenty-two Years On*, which raised the same concerns over disproportionality of FPNs.

Lord Watts (Lab): My Lords, when the Prime Minister was holding a series of parties in No. 10, what were the police doing to enforce regulations?

Baroness Williams of Trafford (Con): My Lords, I was not there, I am afraid.

Lord Young of Cookham (Con): My Lords, the ONS has recently published data that shows, after adjusting for age, that men and women of black ethnicity are four times as likely to die from Covid as people of white ethnicity. What steps are the Government taking to identify and then eliminate the causes of this very worrying disparity?

Baroness Williams of Trafford (Con): My Lords, my noble friend asks a pertinent question—that there is a disparity is not disputed. I know that the Ethnicity Subgroup of SAGE has done some work on this, both the year before last and last year. Factors include people's jobs, and therefore their exposure to risk; household circumstances, such as more people in the house interacting; and financial difficulty in isolating. Vaccine hesitancy is an undoubted factor. The Government are giving financial help with things such as Covid support payments, but I think there is more to be gleaned. On people's responses to Covid, maybe there is something in the physiology or make-up of different types of people—such as the cytokine storms that we talk about and inflammatory responses—that make them susceptible to more serious illness. I think some of that is yet to be uncovered.

Baroness Lawrence of Clarendon (Lab): My Lords, the sad thing is that any new regulations tend to have more impact on the black community. How will the Government make sure that equality means equality for all groups?

Baroness Williams of Trafford (Con): My Lords, the Government are obliged, when they do anything, to make sure that there is not a disproportionate effect on different communities. That requirement is placed on them under the public sector equality duties set out in Section 149 of the Equality Act and covers decisions with respect to the Government's response to Covid-19.

Lord Newby (LD): My Lords, I think the whole House is relieved that the noble Baroness has not been present at No. 10 parties, but it is not a general rule that Ministers can answer questions only about events at which they were present. I wonder if she might possibly write to the noble Lord, Lord Watts.

Baroness Williams of Trafford (Con): I think I answered the noble Lord's question. I was not there; I was not witness to any events that may or may not have happened. As the noble Lord will know—and yes, I do speak for the Government—Sue Gray is doing her review, and the outcome of that will be known in due course.

Lord Browne of Ladyton (Lab): My Lords, on this very point, the question did not require the Minister to have been present to be able to answer it. The question that troubles some people is that the Metropolitan Police has already publicly said that it will not investigate anything but will wait to hear what Sue Gray says and that it is in contact with Sue Gray. The Metropolitan Police has police officers in Downing Street, both inside the building and outside. Surely it is legitimate to ask: are statements being taken from those officers by Sue Gray, and is the Metropolitan Police offering them to Sue Gray's investigation, seeing as it is not investigating this itself?

Baroness Williams of Trafford (Con): The noble Lord asks a perfectly legitimate question. To that I would say that the police are operationally independent of government, but the review and the investigation will take their course.

Lord Rosser (Lab): Do the Government currently believe that there has been equality of treatment between different groups in respect of the enforcement of lockdown regulations by the police since spring 2020? If the Government do not believe that that has been the case, what action are they taking now to address that point?

Baroness Williams of Trafford (Con): As I said to noble Lords, there clearly has been a disparity, with BAME people more likely to have fixed penalty notices issued to them. As I said, the NPCC is going to analyse that in more depth, and will report in due course.

Baroness Altmann (Con): My Lords, given the differences in health status among the different minority groups in the country, with those in the most deprived areas staying healthy only into their early 50s while those in the wealthiest areas stay healthy until around the age of 70, will any assessment be made of the impact on those required to go out to work—to defy lockdown, perhaps—or to find other sources of support if, for example, they were lacking a private pension to tide them over to the ever-rising state pension age, which we were talking about in the previous Question? Lockdowns impose much more hardship on those in

[Baroness Altmann]
poor health, who have much lower resources. I would be grateful if my noble friend could write if she does not have the answer.

Baroness Williams of Trafford (Con): I might have part of an answer, which I addressed in an earlier question. I do not think there is any doubt that nervousness in isolating because of financial circumstances was both anecdotally a factor and found to be a factor in people not wanting to isolate because they needed the money. I talked about Covid support payments, but I am looking now to my noble friend Lady Stedman-Scott. I admire my noble friend Lady Altmann for linking the previous Question to this one, but I am sure that my noble friend Lady Stedman-Scott will be able to answer in more detail in due course.

Elections Bill
First Reading

3.11 pm

The Bill was brought from the Commons, read a first time and ordered to be printed.

Underpayment of Benefits: Compensation
Commons Urgent Question

The following Answer to an Urgent Question was given in the House of Commons on Thursday 13 January.

"I would like to start by extending an apology to Ms U for the experiences that have been highlighted in the Parliamentary and Health Service Ombudsman's report. The department will, of course, formally apologise and make additional payments now that the PHSO report has been published.

I should remind the House that the employment support allowance was introduced in 2008, and from March 2011 the department began reassessing people on incapacity benefits for eligibility for ESA, which saw some claimants underpaid. The department's priority was that all people get the financial support to which they are entitled. It undertook a special exercise to review all cases that were potentially affected and paid arrears where due. We realised how important it was to get this matter fixed and ensure that people get the benefits that they are owed as quickly as possible. We therefore set up a dedicated team, with up to 1,200 staff at the peak of the workload. This has enabled us to complete this important work at pace.

I remind the House that the exercise to correct past ESA payments and pay arrears, following conversion from the previous incapacity benefits, was completed last year, and the then Minister for Disabled People, Health and Work, my honourable friend the Member for North Swindon (Justin Tomlinson), made a Statement to the House in July 2021. All cases have been considered and reviews completed, where the information has been provided, and arrears due were paid. As of 1 June 2021, we have reviewed approximately 600,000 cases and made 118,000 arrears payments to those who are eligible, totalling £613 million. The department published an update on the exercise last Thursday on GOV.UK, which sets out further detail on the progress that it has made on processing the cases."

3.12 pm

Baroness Sherlock (Lab): My Lords, a vulnerable person with multiple health needs recovering from a heart bypass was left for years living on half the money she was entitled to when the DWP moved her on to ESA, which also stopped her getting free prescriptions and other passported benefits. The ombudsman looked into her case and reported that Ms U, as she is known, could not afford to eat properly or heat her home, and that:

"Her mental and physical health declined drastically".

Over 118,000 other people were similarly affected. The DWP eventually paid arrears but is refusing to pay compensation. The ombudsman recommended it paid compensation

"in recognition of its error and the potentially devastating impact it has had on people's lives."

When this matter was debated in the Commons last week, the Minister in the other place said that the Government had published the previous Thursday an update of these cases on GOV.UK. I have searched GOV.UK, as has the Library, and have found no such documentation, so I am dependent on the Minister to answer these two questions. First, can she say whether the DWP has now complied fully with the ombudsman's recommendation to pay Ms U £7,500 in compensation and interest on her £19,832 of arrears? Secondly, will the Government also follow the ombudsman's recommendation to provide remedies to the others who have suffered injustice or hardship as a result of the same maladministration?

The Parliamentary Under-Secretary of State, Foreign, Commonwealth and Development Office and Department for Work and Pensions (Baroness Stedman-Scott) (Con): I will go back to the department and check the first point that the noble Baroness raised. This situation is appalling and awful, and I apologise to all those affected on behalf of the Government and the department. I can confirm that Ms U has had a £7,500 compensation payment and a further payment of interest on the benefit arrears payment of £19,832. There is little more that I can say about her, other than that we have complied completely with the PHSO's point.

On others affected—and I understand the depth of feeling on this—the department has a discretionary scheme that allows special payments to be made to customers to address any hardship or injustice caused by DWP maladministration. Consistent with other large-scale LEAP exercises, special payments under the DWP discretionary scheme will not routinely be made. There is no legal requirement to make special payments as the scheme is discretionary. However, as the Minister for Welfare Delivery said in the other place on Thursday, if anybody believes that they are a special case, they are quite free to make representation to the department.

Baroness Janke (LD): My Lords, as has already been said, this woman has suffered appallingly through maladministration. The Minister did not really address

the point about compensation, which the ombudsman's report specifically asked the DWP to reconsider. Would she look at that again and perhaps come back to us on it? The report also points out that the DWP has put aside its own guidance in the remedy it is offering—so it does seem that the DWP needs to look at this report again.

The noble Baroness, Lady Sherlock, mentioned the very many others affected by these circumstances. Mention was made in the other place of the DWP not having had time to consider this report fully. Will the Minister take back the points we have made here and address in particular the point about compensation, and will she come back to us with a considered response from the DWP to the recommendations in the ombudsman's report?

Baroness Stedman-Scott (Con): I really thought that I had confirmed the situation about Ms U. She has had an unreserved apology. We made a £7,500 compensation payment. We paid the benefit arrears of £19,832.55 and gave money for interest. I think that I have been very clear about that. On the issue of compensation to others, again, it is a discretionary scheme, but I re-emphasise that if anybody believes that they have a special case, they can make representation. I think that clears the way.

Lord Cormack (Con): My Lords, should it not be axiomatic that where somebody suffers as a result of maladministration there is automatically compensation? This is not a criticism of my noble friend, who is the most kind-hearted of people, but we must have compensation if maladministration is the cause of suffering.

Baroness Stedman-Scott (Con): I thank my noble friend for that intervention. I have shared with the whole House the legal position on compensation when it is a LEAP scheme. The PHSO has let the department know what he thinks should happen. I have told noble Lords what the legal position is, and I know that the department needs to respond to the PHSO. When it does that, I am sure that the whole House will be made aware.

Baroness Ritchie of Downpatrick (Lab): My Lords, of equal distress to people is the issue of overpayments in the benefits system, which is allied to the issue of underpayments. What measures will the Minister take, along with ministerial colleagues in the DWP, to restore confidence in the benefit overpayment recovery waiver system—a write-off system that would help people so that they are not forced to pay back money they do not have?

Baroness Stedman-Scott (Con): The noble Baroness makes a very fair point about overpayments. When letters arrive in the post saying, "You owe me X and you've got to pay it back", they do cause distress. I do not argue with that point at all. We have a team that deals with customer interface. It is trying to make the system better all the time. I will go back and speak to the official responsible for that particular sphere of our work and, if it is acceptable to the noble Baroness, I will write to her to see what comes of that discussion.

Baroness Drake (Lab): My Lords, I refer to the Minister's comment about payment of compensation to others being discretionary with a quote from the ombudsman:

> "If Ms U's decisions were typical, DWP will have declined to make others special payments on wrongly applied grounds, will have told them they could not complain to its Independent Case Examiner and will not have told them about the Ombudsman. That means that likely routes for such evidence were closed off."

In the face of that clear statement from the ombudsman, how can the Government continue to refuse to commit to paying compensation to all other victims of the same maladministration?

Baroness Stedman-Scott (Con): I can only tell the House the position of the department. I understand completely the situation and the depth of feeling about compensation for others, and I have to leave that to the Minister for Welfare Delivery and others in the department to consider, although there is no need to. As I say, if people feel that they are a special case and have experienced the same things as Ms U, we would want them to make their case.

Baroness Fookes (Con): My Lords, when something terrible happens, the cry goes up: "This must never be allowed to happen again." Is the department making investigations to see how the error occurred in the first place and how it can be avoided in the future?

Baroness Stedman-Scott (Con): When things like this do happen, they are awful and nobody is proud of them, but I am very pleased to say to my noble friend that the team responsible is looking at what happened and putting in place processes that will ensure that, God forbid, this never happens again.

Lord Davies of Brixton (Lab): My Lords, I take this opportunity to remind the Minister, the noble Baroness and the House of the underpayment of pension to widows and widowers. This is representative of some systematic problems within the department. Will the Minister be reporting to the House on the issue?

Baroness Stedman-Scott (Con): I am not aware of the facts of the underpayment of the widows' and widowers' pension, but as I always try to answer in full, I will go back to the department, find out if there is any correlation and write to the noble Lord.

Business of the House

Motion on Standing Orders

3.22 pm

Moved by ***Lord Ashton of Hyde***

That Standing Order 38(1) (*Arrangement of the Order Paper*) be dispensed with on Wednesday 26 January to enable the Committee stage of the Health and Care Bill to continue before oral questions that day.

Lord Ashton of Hyde (Con): My Lords, on behalf of my noble friend the Leader of the House, I beg to move the Motion standing in her name on the Order Paper.

Motion agreed.

Health and Care Bill

Order of Consideration Motion

3.22 pm

Moved by ***Lord Kamall***

That the instruction of 5 January be revoked and that it be an instruction to the Committee of the Whole House to which the Health and Care Bill has been committed that they consider the bill in the following order:

Clause 1, Schedule 1, Clauses 2 and 3, Clauses 5 to 14, Schedule 2, Clauses 15 to 17, Schedule 3, Clauses 18 to 27, Schedule 4, Clause 28, Schedule 5, Clauses 29 to 40, Schedule 6, Clauses 41 to 43, Schedule 7, Clauses 44 to 61, Schedule 8, Clauses 62 and 63, Schedule 9 ,Clauses 64 to 68, Schedule 10, Clause 69, Schedule 11, Clauses 70 to 74, Schedule 12, Clauses 75 to 80, Clause 4, Clauses 135 to 144, Schedule 17, Clauses 145 to 148, Clause 95, Schedule 13, Clauses 96 to 109, Schedule 14, Clauses 110 to 120, Schedule 15, Clause 121, Clauses 81 to 94, Clauses 122 to 134, Schedule 16, Clauses 149 to 154, Title.

Motion agreed.

Health and Care Bill

Committee (3rd Day) (Continued)

3.24 pm

Clause 14: Establishment of integrated care boards

Debate on Amendment 25 resumed.

Earl Howe (Con): My Lords, the group of amendments to which noble Lords spoke before the break deals in various ways with the appointments processes for integrated care boards. I will deal first with Amendment 32 in the name of the noble Lord, Lord Hunt of Kings Heath, which is designed to ensure that the chair of an integrated care board can be removed only by the integrated care board and not by NHS England. This is a worthwhile issue for debate, and while I recognise the spirit in which the amendment is offered, the noble Lord, Lord Hunt, and I are coming at this from rather different perspectives.

It is worth reminding ourselves that ICBs are accountable to NHS England and thereby to Ministers and ultimately to Parliament. That link is fundamental, given the amounts of public money involved. It is therefore right that the appointments and removals process should involve these bodies. In contrast, the noble Lord's amendment would effectively break that accountability link, because under this amendment, neither NHS England nor the Secretary of State would be able to remove a chair who was acting inappropriately. We cannot have that.

I understand the concern that there should be a safe and robust process for the appointment and removal of the chair of an ICB. I can assure noble Lords that there will be. The chairs of ICBs will be public appointments and therefore managed in line with the Governance Code on Public Appointments and regulated by the Commissioner for Public Appointments. I regret that the Government cannot support this amendment, but I hope I have explained sufficiently why.

Amendment 33 would ensure that the chief executive is appointed by the integrated care board rather than the chair and not subject to the approval of NHS England. I am afraid that, once again, this amendment is not one we can accept. As your Lordships are aware, the chief executive is the accountable officer for the ICB and a crucial person for ensuring that the board is operating effectively. It is therefore right that the appointment should be ultimately made by the chair and approved by NHS England. This approach ensures that we bring together local knowledge and a commitment to ensuring the board is appropriately constituted, while also ensuring that golden thread of accountability from ICBs to NHS England and then ultimately to Parliament. Making the ICB the sole appointing body would break that chain of accountability.

I also remind the Committee that in order to ensure that ICBs can be established and formed in time, NHS England has carried out a selection process for intended designate chief executives which, subject to the passage of the Bill and commencement of the relevant appointment provisions, it expects to be appointed by the chairs of ICBs. All provisional ICB chief executive designates have been agreed by the NHS England appointments and approvals committee, and all candidates were subject to a fair and open recruitment process.

While the current process for appointing designate ICB chairs has primarily been managed and agreed by the NHS England appointments and approvals committee, chiefly in the interests of ensuring that ICBs will be ready to begin work, I reassure your Lordships that we would expect future appointments of chief executives to involve significant engagement from the ICB as a whole to ensure that all chief executives command the confidence of both the ICB and NHS England.

I would also like to address two other significant points the noble Lord raised in his speech: first, the question of conflicts of interest. I can assure the noble Lord that ICBs will have robust duties in relation to conflicts of interest and will be required to maintain and publish a register of members' interests and make arrangements for the management of conflicts or potential conflicts of interest. Furthermore, part of the purpose of the chair's veto is to ensure that candidates for the board who are unsuitable or have unreconcilable conflicts of interest are not appointed to the board.

3.30 pm

The issue of conflicts of interest brings us to the important question the noble Lord raised about the role of members of the board. We believe that the value of these members is in bringing their experience, knowledge

and perspectives to the board, rather than acting as delegates of their organisation or sector. ICB members will be considering the interests of the whole system rather than those of their organisations. I recognise that that will require a degree of cultural change; we are working with NHS England to support ICBs to build and develop these effective and collaborative working cultures. It is worth saying, though, that this work is currently ongoing—we are already in discussion about it. So, once again, and for similar reasons, I am afraid that this is not an amendment I can accept.

Amendment 34 in the name of the noble Baroness, Lady Merron, seeks to mandate

"the involvement of the integrated care board and the integrated care partnership in the appointment of the ICB chief executive."

We agree on the importance of the board and partnership being involved in the appointment of the chief executive, and we would expect chairs to listen to any views expressed by other appropriate persons in taking a decision relating to this appointment. ICB chief executives must be able to command the confidence of both their chairs and their boards. However, it would not be effective or proportionate to place a statutory duty to consult here, as this would establish an extra bureaucratic step in the appointments process. One thing we hope to achieve in the Bill is to cut through layers of bureaucracy. We have worked closely with NHS England, the Local Government Association and a range of system partners to develop the proposals and ensure the minimum amount of disruption with maximum effectiveness. I fear that this amendment would create the type of bureaucracy the Bill is seeking to move away from.

I shall not speak to Amendment 34A in the name of the noble Lord, Lord Young of Norwood Green, as he was not here to move or speak to it. So, I turn now to Amendments 25, 31, 36 and 187; I am grateful once again to the noble Lord, Lord Hunt of Kings Heath, for tabling them. They seek to establish an NHS appointments commission for the appointment and removal of the ICB chair and ordinary members. Although I understand the spirit behind the amendments, I hope to convince the noble Lord that they are unnecessary.

First, and most importantly, a point that I have already made: ICBs are accountable to NHS England—and hence Ministers and, ultimately, Parliament. As a matter of principle, therefore, it is right that the appointment and removal process for ICBs should involve NHS England and Ministers. An NHS appointments commission is not only unnecessary but would cut across the appropriate accountability lines for ICBs. Adding another arms-length body to this landscape would create unnecessary bureaucracy and undermine the aim of merging NHS England and NHS Improvement to create a more joined-up approach across the NHS.

Further, it would also move us away from well-established approaches that, by and large, work well for other NHS bodies. For example, with CCGs, NHS England appoints the accountable officer and the members of the governing body are appointed by the CCG. We are proposing a similar approach for ICBs, through which NHS England appoints the chair, with the approval of the Secretary of State, the chair then appoints the chief executive, with the approval of NHS England, and the statutory ordinary members are appointed through a nomination process. Beyond that, local areas will have the flexibility to determine any further representation on the board in their area, the process for which is to be laid out in the ICB's constitution.

I understand, of course, the presentational attraction of an independent appointments commission, and I am the first to agree that good governance arrangements are essential for managing appointments. However, I gently suggest that a separate appointments body can be remote and lack the local knowledge to ensure that every appointment is a success. In that sense, it would carry risk, and the ICB is too important a body to get this sort of thing wrong.

With a good deal of regret—I do not like to disappoint the noble Lord, Lord Hunt—I am afraid that the Government cannot accept these amendments. However, I hope that I have given the noble Lord some reassurance about the appointments process for the ICB, and that he will feel able to withdraw Amendment 25.

Baroness Thornton (Lab): The appointments commission worked extremely well for many years. Why is it not good enough now?

Earl Howe (Con): As I understand it, the noble Lord, Lord Hunt, is proposing a separate NHS appointments commission. I am suggesting that it would be unnecessary to add that arms-length body to the existing landscape.

Lord Hunt of Kings Heath (Lab): My Lords, I am very grateful to the Minister for his response, which he has clearly put a great deal of thought into. At the end of the day, what is being proposed is a very top-down, hierarchical approach to running the health service. ICBs may be accountable to NHS England and, through NHS England, to the Secretary of State, because the Government are taking power of direction through this legislation. However, it becomes abundantly clear that ICBs do not look outward to their local communities; they look upward to the hierarchies above them.

This is the problem with giving NHS England such power over the chief executive and the chair. Anyone who has worked in the NHS knows that, in the target-laden, panic-ridden approach from the centre to local management, the ICBs will be under the cosh right from the start. For all the wonderful words that have been used about what they will do, the reality is that they will be beaten up by the centre in the traditional "target" approach to running the service. Of course, it did not have to be this way. While it is perfectly proper to have boards making their own decisions and appointments, and being held to account for interventions where necessary, this is such a top-down approach that I do not think it will work. I believe and hope that the House will seek to amend it in some of the ways suggested in these amendments. That said, I beg leave to withdraw my amendment.

Amendment 25 withdrawn.

Clause 14 agreed.

Schedule 2: Integrated care boards: constitution etc

Amendment 26

Moved by ***Lord Clement-Jones***

26: Schedule 2, page 136, line 23, at end insert—

"(ba) a director of digital transformation (see paragraph 7A), and"

Member's explanatory statement

This amendment, and the other to page 137, line 10, ensure that a director of digital transformation is appointed to the integrated care board.

Lord Clement-Jones (LD): My Lords, in moving Amendment 26 I will also speak to Amendments 70, 73, 84, 134, 140 and 160. I start by warmly thanking the noble Lord, Lord Hunt of Kings Heath, for allowing me to speak to and lead on this set of amendments, to which his is the leading name. By the same token, I am delighted to see that he is now back in his place and able to advocate much more knowledgeably than I can the merits of the amendments in this group, which relate to the digital aspects of the NHS and the importance of digital transformation in the health service. They are designed to ensure that a digital transformation duty is set out, five-year plans are made, digital issues are high up on the agenda of the ICBs, and progress in this area is assessed and reported on.

I am sorry that I was not able to contribute at Second Reading on digital or data matters. However, as Chris Hopson, chief executive of NHS Providers, said in his *Observer* piece two Sundays ago,

"we need a national transformation programme that embeds modern technology, 21st century medicine, integrated care closer to home and much greater emphasis on prevention at the heart of our health and care system."

There is huge potential for technology to help health and care professionals to communicate better and to enable people to access the care they need quickly and easily when it suits them. Quite apart from its impact on planning and administration, the technology, as the NHSE digital transformation website emphasises, goes all the way from ambulance iPads through fitness apps to digital home care technology. It ranges from websites and apps that make care and advice easy to access wherever you are to connected computer systems that give NHS staff the test results, history and evidence they need to make the best decisions for patients.

As the recent Wade-Gery report points out:

"Digital technology is transforming every industry including healthcare. Digital and data have been used to redesign services, raising citizen expectations about self-service, personalisation, and convenience, and increasing workforce productivity."

It says that the NHS should be in the vanguard. It goes on to say:

"The pandemic has accelerated the shift to online and changed patient expectations and clinical willingness to adopt new ways of working."

It also says that

"the vaccine programme, supported by so many brilliant volunteers and staff, was only possible through the use of advanced data analytics to drive the risk stratification, population segmentation and operational rollout."

However, the review also says:

"The need is compelling. The NHS faces unprecedented demand and severe operational pressure as we emerge from the coronavirus pandemic, and we need new ways of working to address this. Now is the moment to put data, digital and technology at the heart of how we transform health services … Effective implementation will require a significant cultural shift away from the current siloed approach in the centre with conscious management to ensure intentions translate to reality … This system leadership should be responsible, in a partnership model between the centre and ICSs, for setting out the business and technology capability requirements of ICSs and the centre with the roadmaps to realise these, and for determining the appropriate high level technical standards, and blueprints for transformed care pathways."

I have quoted the Wade-Gery review at length but the What Good Looks Like framework set out by NHSX last year is an important document too, designed as it is to be used to accelerate digital and data transformation. It specifies in success measure 1:

"Your ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care. Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements, and ensure delivery of the system-wide digital and data strategy."

Wade-Gery recommends, inter alia, that we

"reorientate the focus of the centre to make digital integral to transforming care".

In the light of all this, surely that must apply to ICBs as well.

We need to adopt the measures set out in the amendments in this group; namely, specifying in Amendment 26 that there should be a director of digital transformation for each ICB. ICBs need clear leadership to devise, develop and deliver the digital transformation that the NHS so badly needs, in line with all the above. There also needs to be a clear duty placed on ICBs to promote digital transformation. It must be included as part of their performance assessment—otherwise, none of this will happen—and in their annual report, as set out in Amendments 84, 134 and 140.

The resources for digital transformation need to be guaranteed. Amendment 160 is designed to ensure that capital expenditure budgets for digital transformation cannot be raided for other purposes and that digital transformation takes place as planned. It is clear from the Wade-Gery report that we should be doubling and lifting our NHS capital expenditure to 5% of total NHS expenditure, as recommended by the noble Lord, Lord Darzi, and the Institute for Public Policy Research back in June 2018. We should have done that by June 2022 to accord with his recommendations but we are still suffering from chronic underinvestment in digital technology. Indeed, what are the Government's expenditure plans on NHS digital transformation? We should be ring-fencing the 5% as firmly as we can. As Wade-Gery says:

"NHSEI should therefore as a matter of urgency determine the levels of spend on IT across the wider system and seek to re-prioritise spend from within the wider NHSE budget to support accelerated digital transformation."

It adds up to asking why these digital transformation aspirations have been put in place without willing the means.

3.45 pm

I am also mindful of the other side of the coin of the adoption of digital transformation: there needs to be public information and engagement. That is why my noble friend Lady Barker and I have tabled

Amendments 70 and 73, designed to ensure the provision of information about the deployment of treatments and technology as part of ICBs' patient involvement and patient choice duties. Without that kind of transparency, there will not be the patient and public trust in the NHS adoption of digital technology that is needed. Rightly, success measure 1 of the NHSX What Good Looks Like framework includes that an ICS should, inter alia,

"identify ICS-wide digital and data solutions for improving health and care outcomes by regularly engaging with partners, citizen and front line groups".

Success measure 5, titled "Empower citizens", says:

"What does good look like? Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being."

So in the NHS's view the engagement and provision of information about the deployment of new technologies is absolutely part of the delivery of a digital transformation strategy.

In essence, the amendments would enshrine what is already there in Wade-Gery and best practice guidance where it relates to digital technology and transformation. We should be making sure that our NHS legislation is fully updated in line with that report and with the guidance on what success looks like for the digital age. I hope the Minister agrees to take the amendments on board, and I look forward to hearing his reply. I beg to move.

Lord Hunt of Kings Heath (Lab): My Lords, I am grateful to the noble Lord, Lord Clement-Jones, for speaking so eloquently in support of this group of amendments. There are a number of amendments relating to data in this Committee and they fall into three categories. The first category, the group that we are debating today, is about the prioritisation of the digital transformation in the NHS. The second group looks at specific patient groups and the potential of data to improve their care outcomes. The third set is about confidentiality of data as far as patients are concerned. My view is that all three run together.

Like the noble Lord, Lord Clement-Jones, and the noble Baroness, Lady Cumberlege, I am enthusiastic about digital transformation in the NHS; indeed, I believe it is the only way we can hope to meet the challenges that healthcare faces over the next 20 or 30 years. However, there are two conditions. One is that the integrity of patients' data is assured for individual patients. That has not always been the case in the past, and the debacle of care.data is a salutary warning of what can happen if we do not protect patient information in an appropriate way.

The second condition is resources. I was very glad that my noble friend referred to the issue of resources and to the Wade-Gery report, which is the most recent report looking at the arrangements to support digital transformation in the health service. Wade-Gery reported that

"transformation funding is … split between revenue and capital and dispersed across the organisations. Tech funding is variable, often diverted and not necessarily linked to strategy and outcomes, incentivising either monolithic programmes or small-scale initiatives."

She commented:

"The requirement for digital transformation in other sectors has driven up the proportion of their spend on digital and technology".

It has been well-known, for many years, that the NHS locally has not been spending sufficiently on data and data transformation. The latest estimate from NHS England is that the NHS spends less than 2% of its total expenditure on IT, while the noble Lord, Lord Darzi, and the IPPR suggest that this should be nearer 5% by 2022. I say to Ministers that, unless they can find ways to ensure the NHS starts to spend at that level, we are simply not going to achieve the kind of transformation we want.

One way to do that is to ensure that, at the ICB level, there is an official charged with driving this forward at the local level. We know, in general, in relation to boards of the health service, that the data/digital leadership often does not have a seat, in contrast to many organisations. This is why we think that needs to change. Overall, we believe this set of amendments would enable the Government and Parliament to show how important it is to prioritise the kind of digital transformation that we want to see.

Baroness Cumberlege (Con): My Lords, I support these amendments but first I believe in putting right wrongs. I failed to declare my interests in last Tuesday's debate, so I took advice from the registrar. He assured me that I do not have to give a full account of my life and times, which is a great mercy to everybody, but I do have to declare what I am currently involved in and the remunerations. I serve on the Maternity Transformation Board, which is owned by NHS England, and the maternity Stakeholder Council, which is also supported by NHS England but is much more of a free agent.

I thank the noble Lords, Lord Clement-Jones and Lord Hunt of Kings Heath; it was a very rounded, fulsome and clear introduction to these amendments. I want to pick up the issue of trust, because both noble Lords linked trust and confidentiality. That is absolutely essential. We will not get the support or trust of the public if we do not respect their confidentiality, and I will say a word about that in a minute. I support Amendments 84, 134, 140 and 160—I have added my name to them. I also support Amendments 70 and 73, and wish to comment on those.

I strongly support digital transformation. Amendments 84, 134 and 140 place a duty on integrated care boards to promote digital transformation and to produce their own five-year plans. It will need money, so Amendment 160 requires the NHS to spend at least 5% of its capital allocation to achieve it. That is right, as digital needs sustained resource—it is not simply a "nice to have"; it is absolutely essential for the future of our services. I have talked to visitors from the USA and cannot believe how antiquated they think our systems are. In many places, they are still in the dark ages, so we have to invest in digital.

I support the increased use of digital technology in healthcare largely because of my involvement in two major inquiries into NHS services in the last few years. One evening in 2014, I had a telephone call from Simon Stevens, the chief executive of NHS England,

[Baroness Cumberlege]
before he was knighted and welcomed into your Lordships' House, where he has already made a very significant contribution. He invited me to chair an inquiry into maternity services for England. The noble Lord has a sense of humour: he gave me nine months in which to deliver.

I set up a panel and we delivered in time, calling our report *Better Births*. Our 28 recommendations were accepted by NHS England, which then set up the Maternity Transformation Board and the Stakeholder Council, on which I have declared my interests. The Stakeholder Council is interesting because it is full of a wide range of people. A lot of charities, in particular, are on that council, and add a lot to the work that we do.

Two of the 28 recommendations are particularly relevant to this Bill and these amendments. We recommended that every mother should have her own digital maternity record, which she would create with her midwife. This record would set out the plans for managing her pregnancy, the birth and aftercare, which is so necessary for the baby, the mother and, I would add, the family. The mother's record would then be accessible, with her permission, to all those contributing to her care. In future, we could see it being part of the child health record, and possibly the lifetime health record of the mother.

Although some progress has been made on improving access to NHS health records, we are still some way from achieving this, or the ambition set out in the *NHS Long Term Plan* for every citizen to have their own personal health record. We need to galvanise the NHS to move quickly and capitalise on the enormous potential that digital offers. That is what these amendments are designed to do. I am sure my noble friends on the Front Bench will consider them carefully and assess the potential that they offer.

I also recently had the privilege of chairing an investigation into the safety of medicines and medical devices; our report was called *First Do No Harm*. Thousands of women and children suffered avoidable harm relating to the medicines and one of the medical devices which we reviewed. They continue to live with the terrible consequences today. This harm did not take place in one isolated moment; it has spanned years and even decades. Why was it not detected and stopped? Many people could have been spared the misery it has been for them and their families.

Part of the answer to that lies in the absence of data. We found that data was not collected or that, when it was, there was no attempt to link data to identify patterns of concern. Paper records, such as there were, were incomplete, dispersed, archived or destroyed. The healthcare system could not tell us how many women had taken the epilepsy drug sodium valproate and gone on to have damaged babies. It could not tell us how many women had pelvic mesh implants, or which implants were used, or where and when.

4 pm

We were astonished and deeply worried: the system was flying blind. We said that basic information about implantable devices such as mesh was so important that it must be collected, and it must be mandated. We need the name of the patient, the unique device identified, the surgeon, the hospital, and so on. At least then, if a concern about the device is subsequently raised, it will be possible to trace those who have been affected.

The previous Secretary of State agreed with us and issued a mandate for a database. Some noble Lords will remember the Medicines and Medical Devices Bill. It involved a great deal of discussion and persuasion in this House, but many of our amendments had government support and were enacted. Through these debates, the concept of the independent patient safety commissioner was discussed and strongly acclaimed. I am delighted that last week, an advertisement was published on the role, context and responsibility of the commissioner by the Department of Health and Social Care. I thank the department, the Ministers and the previous Minister for their unstinting encouragement and support, which have enabled this to happen. We hope that some outstanding candidates will apply for this position.

Of course, mining data will be an essential tool for the commissioner's office. It is only by linking access and linking across that we will be able to say: "Stop. This doesn't look right. We need to investigate and ensure that we achieve a safer service." Digital data is powerful; it is an enabler and it can be a force for good. But we must treat patients' records with care and we must respect the person to whom they belong. That is not the doctor or the NHS: that is the patient themselves. Later in Committee, we will consider amendments that address the sharing of records and consent. I am sure that we will have a lot of debate on that.

Amendments 70 and 73 are very important too. They would ensure that patients are made aware of new technologies and treatments and, crucially, that patients are involved in decision-making about these treatments and technologies. I know from the experiences that we heard about and the huge amount of evidence that we received in our review that that did not happen. That contributed to avoidable harm on a really shocking scale. Likewise, I have no doubt that if greater progress on digital records had been made at that time, the questions that we had in our review about how many people had been harmed, when and how, would have been answered. Digital records enhance patient safety, so I strongly support these amendments.

Baroness Harding of Winscombe (Con): My Lords, I too stress the importance of digital transformation in our health and care services. I thank the noble Lords, Lord Clement-Jones and Lord Hunt, and my noble friend Lady Cumberlege for their contributions and for enabling us to have this debate.

The way that the noble Lord, Lord Hunt, has characterised this as three different issues interwoven is an extremely good way to think about this. I completely agree that the integrity and confidentiality of patient data, and having the resources to lead transformation, are essential components. I would just like to add a contribution on the third element, the prioritisation of digital and data. I too am going to cite the Wade-Gery review. It is really important that those of us who have worked in digital transformations in other sectors also encourage our health system to look outside. All health

systems are probably 10, perhaps 20, years behind other sectors—financial services, retail and, dare I say, even politics—in their digital journey.

This is not just an NHS issue: it is a health sector issue. One reason why that is the case is that we have tended in health to think that digital is "other", something separate from healthcare itself; whereas, actually, healthcare is that most human of services and digital is an enabler. It is the means, not the end, and it is hugely important that we think of prioritising digital and data as prioritising the overall transformation of care, rather than the digital transformation. This is not just semantics: it is important that everyone owns that transformation, most importantly our front-line clinicians, and that it is not something that is parked separately.

When I was growing up, my parents' generation abdicated responsibility for the family VCR to the children. Certain business leaders, 10 or 15 years ago, abdicated responsibility for their technology transformation to their chief technology officer. If we really want to see the benefits of digital transform our health and care system, we must not abdicate that transformation to a digital transformation team. It needs to be the business of everyone—most importantly, our leaders. I hugely support the spirit of these amendments and particularly the amendments looking specifically at funding and a duty to lead transformation, but I caution against creating a post of digital transformation because that needs to begin with the chair, the chief executive and the medical and nursing directors, not just an individual with digital in their name.

Lord Mawson (CB): My Lords, my colleagues and I built the first online facility for the voluntary and social enterprise sector in this country in 1997, called CAN Online. We learned rather a lot from doing that, and I actually came to many of the conclusions that the noble Baroness, Lady Harding, is telling us about. When we started this, we naively thought that this online environment was going to solve all our problems, as if it sat "out there" somewhere. We bought 12 computers: they came in very big boxes at that point, as noble Lords might remember. We put them in a room in a conference centre—we were in the Cotswolds—and I invited 12 entrepreneurial people working in the social sector to come and share a few days with them. We connected them all up. We thought it was about technology, but we actually we discovered that it was all about people and relationships; that this technology was simply a tool—an enabler—to facilitate a marketplace that we needed to build between us.

We began to understand that this was not about large systems up there that you plonk in the middle of things in some separate way. It is actually organic: they are very connected, and you need to co-create it and invent it together around the real needs and opportunities that are presenting themselves. I think this technology is telling us something about what needs to happen to the health service. It is organic; it is entrepreneurial; it is about creating a learning-by-doing culture. My colleagues and I have seen examples in the NHS and other parts of the public sector where millions of pounds have been spent on systems that have landed from Mars and have not worked.

First, we must understand the detail of this technology, and the opportunity that it brings. Later on, as we go through the amendments, I will share with noble Lords some technology platforms that we are working with across the country that have absolutely understood this. When they are engaged with the NHS, instead of the system getting behind them and building on their success and knowledge, it never follows up on the conversation with them. They never heard from the NHS again. There is a disconnect going on, and a fatal misunderstanding of how this new world now needs to work.

I welcome these amendments and this conversation, but we must understand—from those of us who built some of this stuff, even in the clunky old days of 1997—that it is all about the relationship between people and technology and a learning-by-doing entrepreneurial environment.

Lord Bethell (Con): My Lords, I, too, praise the noble Lord, Lord Clement-Jones, for his analysis and for rightly identifying the important connection between trust and confidentiality, and the noble Lord, Lord Hunt, for his diagnosis. In particular, I double up on the praise for Laura Wade-Gery and her report, which provides a huge amount of insight for this debate, and praise also my noble friend Lady Cumberlege, who has been a pioneer and remorseless champion of safety. She is entirely right that we are talking here not just about productivity but safety. Data saves lives, and her report made that point extremely well.

Basically, I just want to repeat absolutely everything that my noble friend Lady Harding said about ambition. My concern about this debate is not the analysis, which I think is spot-on; it is the level of ambition. I have lived through digital transformations. I lived through one in the music industry, and it did not just come from digital transformation officers—although I know that that is not the point of these amendments—but required the commitment of everyone from the superstars down to the roadies. Everyone in the industry was affected; it was a massive revolution; it led to an incredible improvement in the industry; but it was hard fought and a difficult thing to go through.

I have also lived through a revolution in digital in healthcare. Over the past two years, we saw amazing breakthroughs in individual areas, the vaccine rollout being a really good example to which my noble friend Lady Cumberlege referred, but also in non-present appointments with GPs and in other areas. But it took a pandemic to drive that progress as quickly as it did, and I never again want to see such a horrible emergency be required to create change.

The message to the Minister is that the Bill is a remarkable enabling document that helps the healthcare system in the UK make important progress across the board on many different areas, but the big challenge of our generation is digital transformation. It does not require a lot of legislative change. These amendments are not what will make a difference. My noble friend needs to have the energy, passion and determination to see through that transformation when he gets back to the department, and I hope that the Bill gives him the tools to do that.

Baroness Thornton (Lab): I thought noble Lords would have more to say about digital matters. I shall respond to this group very briefly, because my noble friend Lord Hunt, the noble Lord, Lord Clement-Jones, and others have very adequately covered the issues: the potential for digital transformation, the need to use patient data, the need for resources and, as the noble Lord, Lord Bethell, just said, enthusiasm and leadership.

The noble Baroness, Lady Cumberlege, as she always does, brought us practical applications of the reasons why the amendments are necessary, and it brought to my mind that my digital interface with the NHS is a good example of someone who is absolutely at the coalface. I am part of UCLH's digital patient management system. It does not talk to my GP and it does not talk to the Royal Free, which is where one has one's tests in the part of London I live in, and I think, "For goodness' sake, we really ought to be able to do better than this".

Earl Howe (Con): My Lords, I am very grateful to the noble Lords, Lord Hunt of Kings Heath and Lord Clement-Jones, the noble Baroness, Lady Thornton, and my noble friend Lady Cumberlege for bringing these amendments for debate before the Committee today.

Once again, we are dealing here with an important set of issues. First, Amendments 26 and 35 would ensure that integrated care boards appointed a director of digital transformation. The Government fully agree with the spirit behind the amendments, ensuring a strong local focus on digital transformation. However, looking at the pros and cons, we must balance the desire to go further—which we all want—with the important principle that I have articulated before: that the provisions in the Bill should not be too prescriptive when it comes to membership requirements. As we have discussed, it is an essential principle of the Bill that there must be local flexibility to design the board in a way most suitable to each area's unique needs.

4.15 pm

As your Lordships will be aware, local areas can, by agreement, go beyond the legislative minimum requirements to appoint individuals with the necessary experience and expertise to address their needs. As such, prescribing particular roles in these provisions is not necessary. What I can say is that developing the digital capability of local health and care services is one of the areas that we would expect ICBs to prioritise. It is an area of significant investment centrally, as I shall come on to explain in a moment, and of similar investment by local commissioners; it needs good local leadership, undoubtedly.

To buttress this investment, the NHS has been set a very clear set of expectations in relation to digital transformation. This set of expectations is even called *What Good Looks Like*, and it will be the benchmark for integrated care boards. It sets the criteria against which they will be assessed for their effectiveness in using digital technology to support improved outcomes for patients.

The first measure of success is that the local system has a clear strategy for digital transformation and collaboration, with the right leadership. Integrated care boards are expected to have digital expertise and accountability in their leadership arrangements, but, as the noble Lord, Lord Mawson, brought out so well, we also expect a general development of digital competence in the board, and investment across the local system in expertise in building digital capability. That process certainly could be assisted through a chief information officer and other roles.

We will provide resources, including a non-statutory assessment framework for organisations to measure their level of digital maturity against the characteristics set by *What Good Looks Like*. It will help identify gaps and prioritise areas for local improvement. Assessments will be repeatable annually so progress can be tracked year on year.

We are not just setting expectations; we will be testing progress. This is obviously where the strength would lie in any expectation-setting process, rather than whether or not it was in statute. The Committee may like to know that my right honourable friend the Secretary of State and my noble friend Lord Kamall have regular meetings with NHSX, NHS Digital and NHS Transformation about the safe and ethical sharing of data and appropriate ways to break down silos. Ministers are in no way distancing themselves from those important issues; quite the reverse. *Data Saves Lives* is the name of the draft strategy that we published, and it is a title that vividly reminds us of what is at stake here.

I just say to my noble friend Lady Cumberlege that I am also especially pleased that we are in the process of appointing the first ever patient safety commissioner for England. The role is currently open for applications until Tuesday 25. As she knows, the patient safety commissioner will be responsible for promoting good practice, for calling the healthcare system to account and for identifying and monitoring potential problems across the system.

While on the topic of digital transformation, let me turn to Amendments 84, 134 and 140, which seek to place a duty on ICBs to promote digital transformation, accompanied by the publication of a five-year plan for digital transformation, with an update at least once every five years. The use of digital technology has been crucial to meeting the demands which Covid-19 has placed on health and care services. It has given renewed impetus to an area which in the past, as the noble Lord, Lord Hunt, will know from his considerable experience, has been problematic for the NHS.

Leading the process of digital transformation locally is a significant role for the integrated care board, but this should be part of its general duties rather than a separate duty. I am afraid that I do not think it would be proportionate or effective to have a stand-alone statutory duty, as it would require the creation of a separate planning and reporting process, which we do not think is necessary. As I have made clear, we will test the progress of ICBs in this area against the expectations we set.

There is a broader point, which my noble friend Lady Harding brought out cogently: digital transformation is most effectively done as part of wider service and pathway transformation rather than looked at as a separate activity. Integrated care boards will be required periodically to produce strategic plans, which we would

expect to include digital transformation and its interaction with other aspects of planned transformation. A separate statutory duty is therefore unnecessary and risks misalignment between digital transformation and wider service transformation when we would want them to go hand in glove. Rather than risking this, I ask the noble Lord to agree with our approach of placing digital transformation at the heart of the ICB's general duties.

Of course, any efforts to promote digital transformation must be incentivised through effective funding. Amendment 160 would ring-fence 5% of NHS organisations' spending to be dedicated to digital transformation. The noble Lord, Lord Clement-Jones, asked about the amounts of money that we are earmarking for this. Over the next three years, we are investing centrally £2.85 billion in capital, with £2.9 billion of revenue on top of that. Within this, more than £2 billion has been set aside for digitising the front-line NHS, in addition to local investment by commissioners. However, noble Lords will understand that we have a long-standing and well-tested principle of not ring-fencing investment in the NHS. It is fundamental to the flexibility of local commissioners and to the principle of local, clinically led decision-making. We would not want to tie the hands of local trusts specifically to spend a certain amount of money in one area and not in other areas, nor would we want to be prescriptive about whether NHS organisations should use capital or revenue spending to deliver digital transformation, particularly as the market is in the process of moving towards revenue-based products.

I can also inform the noble Lord, Lord Hunt, that consideration has been given to whether a minimum tech investment policy for NHS organisations could helpfully support digital transformation. The conclusion was that such a policy would face practical challenges, including difficulties in monitoring and enforcing compliance, and could cause a range of unintended consequences, including encouraging organisations to focus on hitting the target rather than maximising value from appropriate investments in digital technology. We also felt that it would not address many of the underlying causes of low levels of digitisation. Instead, we would advocate a flexible approach, giving local organisations the ability to spend the money in the areas which are urgently needed. This must be accompanied by clear national standards defining what a good level of digitisation is and guidance and support, including for local skills development, so that organisations are supported to invest effectively. If local NHS organisations fail to meet the required standards of digital transformation, there are other levers at our disposal to enforce compliance, including the oversight arrangements used to manage organisations' operational performance, financial sustainability and the safety and quality of care delivered.

Amendments 70 and 73 specify that patients should be involved in decisions relating to the provision of information about the deployment of new treatments and technologies, and the provision of this information to enable patients to make a choice with respect to aspects of healthcare provided for them. I believe that the Bill, as is, achieves what the noble Lord and noble Baroness seek to achieve through these amendments. An integrated care board, in the exercise of its functions, must promote patient involvement in decisions relating to their care and treatment, and this would likely cover providing information about available new treatments and technologies where there is an impact on the care received. The Bill also includes duties to promote research and innovation on matters relevant to the health service and the use of evidence obtained from research, so I believe that the Bill will allow local NHS bodies to best engage and involve patients and the public, supported by national guidance.

Turning to Amendment 78, the first part of the amendment requests that integrated care boards review all innovations. I completely appreciate the intentions behind the amendment, but it is unclear to me what additional benefit such a review would produce. As noble Lords know very well, the National Institute for Health and Care Excellence already plays an important role in ensuring that patients have access to promising new innovations by making recommendations on whether health technologies represent a clinically and cost-effective use of NHS resources. Where NICE makes a positive recommendation, NHS commissioners are under statutory obligations to fund the technology. This requirement will carry over to integrated care boards.

The second part of the amendment seeks to appoint a dedicated innovation officer to each board and develop and maintain a system to keep up with innovations. The Accelerated Access Collaborative, or AAC, the umbrella organisation overseeing the health innovation ecosystem, is working with NHS partners to look to embed research and innovation objectives within the new statutory ICBs. For example, as articulated in their job descriptions, a clear requirement will be placed on ICB chief executives and chairs to foster a culture of innovation. We also have existing reporting tools at our disposal to monitor the use of innovative medicines and medicinal products. This includes NHS Digital's innovation scorecard and the AAC scorecard. Finally, alongside work that is under way to strengthen our ability to monitor progress, the AAC is scoping the development of an overarching innovation metric to help identify and address unwarranted variation.

Against that background, I hope that I have said enough to persuade my noble friend to move her amendment when the time comes for it to be called and to persuade the noble Lords, Lord Hunt and Lord Clement-Jones, not to press theirs.

Lord Mackay of Clashfern (Con): My Lords, the Minister is much in agreement with others that the leadership being enthusiastic for progress is important. I understand that nominations have already been made for the various positions that are likely to come up. To what extent has enthusiasm for digital transformation been a criterion in nominating those people? It is vital that the leader really believes in what is to happen if it is to happen at all. Therefore, it would be useful to know to what extent that consideration has applied in the prospective nominations of people for the local positions.

Earl Howe (Con): Noble Lords will remember that, even 10 years ago, when I was appointed as a Health Minister, there was an acronym, QIPP, which stood

[Earl Howe]
for "quality, innovation, productivity and prevention". While I think the acronym has largely fallen out of use, those four principles remain alive and kicking in the strategic thinking that happens at the top of the health service, and indeed in the department.

4.30 pm

I can say to my noble and learned friend that the importance of innovation is absolutely at the heart of the way in which the leaders of the ICBs are being chosen. They need to be people who look ahead, think strategically and value innovation, not just for itself but for the way in which it can transform care. Not all innovation is good; we must remember that. We should look only at innovation that has a positive effect on the care of patients and service users, but digitisation is undoubtedly one of those areas of innovation on which we must concentrate. I am confident that the leaders that are now lined up have that ambition very much in mind.

Lord Clement-Jones (LD): My Lords, I thank the noble Earl, Lord Howe, for his very considered response. We have had a very rich debate, and I thank all the speakers. It has been a privilege to take part in what I think the noble Lord, Lord Bethell, called this "conversation", because we have heard huge experience and authority, right across the board, about the way we might digitally transform the NHS.

In a sense, I think it is about means, not ends: we are trying to reach the same end but we disagree on how to get to that objective. At the core of that disagreement, and no doubt where we will have considerable debate later on in the Bill, is where the digital transformation aspect fits with data confidentiality and data sharing—all of which is necessary as part of digital transformation. I listened with enormous interest to what the noble Baroness, Lady Cumberlege, had to say on that. We have to get this equation right, and we have to build public trust. I say "build" public trust because I do not think it is completely there, post the GP data grab, as it has been called, of last year. We will come on to that on future occasions.

I feel somewhat that the noble Earl, despite his mellifluous approach to these matters, was rather throwing the book of arguments at the need for any form of amendment to the Bill. He always does so with great style, but I was not totally convinced on this occasion. He mentioned the principle that we should not be too prescriptive—in that case, why are we legislating? We are trying to legislate for what the priorities for the health service are in the current circumstances.

Lord Hunt of Kings Heath (Lab): Does my noble friend not think there is an interesting contrast in saying that we must not be too prescriptive but, for NHS England, we are going to tell it what to do?

Lord Clement-Jones (LD): Absolutely. I think the noble Lord, Lord Mawson, talked about a disconnect in another context, but that is probably the word I would use in these circumstances. The Government say that they are going to prioritise good local leadership but do not want to be too prescriptive about who is on the board of the ICB; that they want a clear strategy for digital transformation but do not want to make it a duty; and that a general level of competence and expertise is required but, again, "Oh, no, we don't want any digital duty; that would be a little bit too prescriptive".

We need a level of digital maturity, and a regular set of digital maturity assessments. I liked the sound of that, but faced with all the other duties that ICBs will have, which ones are they going to prioritise—the ones that are built into statute, or the ones that are part of a What Good Looks Like programme? The noble Earl quoted exactly the same document that I had access to. It is a splendid document but, without some form of underpinning by legislation, it is very difficult to see ICBs giving priority to that.

Of course, the other argument the noble Earl made was that if we had a separate duty, we would have to have a whole separate planning process. That is not how these things work. When you have a set of duties, you try to do it in a holistic fashion. You do not say that we need one plan for this duty and another for that duty. If you are going to use your resources sensibly and the capabilities within your organisation in the right way, you need to do it in a planned programme, right across the board.

On the whole issue that having a separate statutory duty risks misalignment, I thought that was where somebody had really been creative and woken up with the inspiration that this was the final killer blow in the arguments being made.

I listened with great interest when the noble Earl came to the question of funding. I have not done any calculations in my head, but I bet that £2.85 billion cap ex spending over three years does not equate to 5% of the NHS budget. As my noble friend intimated to me, when you look at the cost of some of the digital developments that have taken place over the last year or two, you will see that they are highly expensive, in both revenue and capital spending. The noble Earl talked about not ring-fencing We all know the problem of distinguishing between capital and revenue in public spending. That is not to say that that is necessarily right.

Finally, on the idea that we must not tie hands—what is legislation designed to do but to set out parameters?

I thought that the aspect of patient engagement was quite interesting, and I will need to re-read what the noble Earl had to say, because it may be that the current set of duties within the Bill provides for that. That may be a glimmer of hope. Indeed, the whole question about the duty to foster a culture of innovation is a kind of fig leaf. What board is going to treat that as an absolute duty that it needs to plan in and set particular duties to its team for? In a sense, it will be an optional extra if we are not careful.

To tell your Lordships the truth, I am not entirely convinced that we are going to be able to—in the words of the noble Baroness, Lady Cumberlege—"galvanise" the NHS. I thought that was a splendid word; it has a certain electricity about it. I do not think anything in the current Bill is going to deliver that galvanising impact, and we will be left with the disconnect that the noble Lord, Lord Mawson, talked about if we are not careful. But in the meantime, I beg leave to withdraw my amendment.

Amendment 26 withdrawn.

Amendments 27 to 36 not moved.

Amendment 36A

Moved by ***Baroness Finlay of Llandaff***

36A: Schedule 2, page 137, line 23, leave out "one member" and insert "two members"

Member's explanatory statement

This amendment would strengthen minimum clinical representation on Integrated Care Boards by ensuring there are at least two primary care members.

Baroness Finlay of Llandaff (CB): My Lords, I must declare that I am an elected member of the BMA ethics committee and a past president. The BMA has been particularly concerned about ICB membership. I know we have already debated this, so I expect this group to be quite quick—I am sure the Committee would also hope that.

The Bill sets out a core minimum membership of integrated care boards, but this does not go far enough. We have just discussed not being prescriptive, but there are dangers in that. There is no guarantee of clinical leadership on the board and there is a real danger of undercutting truly representative clinical leadership by failing to retain some of the positive elements of clinical commissioning groups. Clinicians are already demoralised and a failure to give space to their voice and enthusiasm will only worsen this.

ICBs should have clinical representation from primary care and this amendment suggests that there should be two people for this, given the wide area that the boards cover and the very different types of practice within each area. Boards also need a secondary care clinician who is in a front-line, not a management, role and a public health representative. As we have already discussed, without public health representation on the board, there is a real danger that the evidence of health gain and the potential to reduce inequality will not be adequately voiced. The board needs public health input to be able to act as a population health organisation.

Some boards have acknowledged the shortcomings and allocated additional positions for general practice, secondary care and public health within their draft constitutions, but others have not. They appear to be ignoring the voice of the very people who work in front-line healthcare. Unless these voices are heard, along with the voice of public health, there is a real danger that the boards' decisions will be distant from the reality and that they will become bad decision-makers themselves by losing clinical trust and confidence. I hope that the Government will rethink and ensure that the boards are able to have members who can provide a solely professional view of the whole population for whom the board has responsibility. I know we have already debated much of this, but I want the Government to think again, given the dangers of a further demoralisation in both primary and secondary care. I beg to move.

Baroness Walmsley (LD): My Lords, it is essential that the board have available to it the skill set that you find in people at the clinical front line. I was interested to see that, putting the amendments from the noble Baroness, Lady Finlay, together, we have three people who are not representing one of the big acute hospitals, and one who is. Given the danger referred to by a number of noble Lords that the big acute hospitals will continue to have more influence in an integrated system than perhaps they should, that is a good element of putting the two amendments together.

As I said, it is important that clinical knowledge and experience be available to the board, but I would like to know that there is a balance and that this does not overwhelm other skill sets which all of us want to see represented; that became clear in the discussions we had last week about who should be on the board. With that caveat—the noble Baroness, Lady Finlay, might respond to that if she chooses to withdraw her amendment—I offer qualified support to what she is suggesting.

Baroness Thornton (Lab): The two amendments put forward by the noble Baroness, Lady Finlay, add to those we have already discussed about who should serve on the board and what range of experience its members should have. Of course, we all agree that it is important to have clinical experience brought to the board. However, if this is about integration—I may have said something similar to this last week—mental health, social care, primary care and public health need to be part of the planning on these boards. In that respect, I give these amendments my support, but I think we need more discussion about this. At the moment, as far as I can gather—perhaps the noble Lord can enlighten me—the boards are pretty much made up and I do not think they fulfil the criteria of things we will need to bring to bear to have properly integrated planning in the places covered by these ICBs.

4.45 pm

Lord Kamall (Con): My Lords, I am grateful to the noble Baroness, Lady Finlay, for bringing these amendments before the Committee today. I am also grateful to all noble Lords, who have offered me two bits of advice thus far: first, "You can make your life a lot easier if you just accept our amendments"; and secondly, "Don't worry about the other amendments, just accept mine; that's who needs to be on the board". I hope all noble Lords understand the sort of advice I have been given, as I consider my response.

The noble Baroness, Lady Finlay, raises an important point and there is clearly understanding and support for ensuring that there is primary care representation on ICBs. This is a topic that we have both discussed and are likely to return to. I am in danger of sounding like a scratched record, for those who remember vinyl—I am told it is making a comeback—but I hope not to, or to labour the point too much, by repeating the arguments we have already discussed at length.

We fully agree that the membership of ICBs should include individuals from a number of places and this is why we have set a requirement that ICBs should have at least one member nominated by the primary medical care providers on the board. The noble Baroness, Lady Walmsley, made a couple of very useful points here. The board should have available to it the talent and skill sets that it needs, but there should also be a

[Lord Kamall]
balance that does not overwhelm any one set of skills. That is one of our concerns as we look at not overprescribing the make-up of the ICBs.

The noble Baroness, Lady Thornton, is absolutely correct that, given the debates we have had up to now, there will have to be more discussions on the ICBs between this stage and the next. I accept that; we will have meetings and roundtables to discuss this, and I know there might well be more amendments on the membership of the ICBs. Before those discussions, I would just reiterate at this stage that this is a floor, not a ceiling; it is a minimum requirement. ICBs are able to appoint individuals with those skills as they see fit, and we would hope that they would, to make sure that they meet the health requirements and tackle the health challenges of the local areas they cover. As the noble Lord, Lord Mawson, and my noble friend Lady Harding of Winscombe said last time we discussed these issues, it is important not to be overprescriptive and close off the opportunities to tailor boards to each local area. The noble Lord spoke very eloquently about his experience of building a board in a particular place, which might have been quite different, had it been in another place.

Turning to Amendment 41B, the noble Baroness, Lady Finlay, raised an important point about ensuring there is sufficient representation of clinicians with experience of public health and secondary care. We fully agree that ensuring that sufficient clinical expertise is available to the ICB is critical. We do so through a duty imposed on ICBs to seek advice from persons with a range of professional expertise in, for example, prevention, which noble Lords have said we should focus on, diagnosis or treatment in illness, and the protection or improvement of public health. This applies at every level of the ICB and impacts how it discharges its functions. As a result, I can assure the Committee that the clinical voice will be heard loud and clear at every level—not just at the ICB or ICP level, but in the health and well-being boards.

For the reasons I have discussed, I am afraid that I do not agree at this stage that the best way to ensure this would be by requiring two additional members of the ICB. This would take away the flexibility provided to ICBs and potentially inhibit their ability to respond to their own area's local needs. Finally, I would not want to risk ICBs believing that their duty to seek clinical advice would be discharged solely by appointing two clinicians to their board—saying, "Okay, we have those two clinicians, that box is ticked". The noble Lord, Lord Scriven, made a point about a staff member called Gladys, whose role ticked a box. We have to be very careful that we do not repeat that mistake with two tick boxes. Instead, ICBs should seek appropriate advice from subject matter experts. This may mean seeking advice from different clinicians for different issues and developing different models of seeking advice for different types of decision.

As I said earlier, we will have discussions about the whole ICB composition between this stage and the next. In that spirit, I hope the noble Baroness, Lady Finlay, will be a little reassured and feel able to withdraw her amendment.

Baroness Finlay of Llandaff (CB): I am most grateful to both the noble Baronesses, Lady Walmsley and Lady Thornton, for their comments, which I share. In the previous debate, I argued that we should have people from the allied health professions, and I do not dissent from that. This is not to replace them at all. I also completely recognise the Government's comments that we need talent and a skills set. Having a balanced board means that you have to have the range of skills. Some people may bring several skills to the table, but they do not automatically bring them because they have a label on their head saying where they come from.

The other difficulty that we will face is that boards need to have contemporaneous experience in an area—and people go out of date remarkably quickly in different areas. The pandemic has shown how some areas have changed enormously in a very short space of time. The representations that I have had from the BMA, at a professional level, have been about how we make sure that the ICBs will be up to date with that contemporaneous input coming through all the time. I am glad to hear that the Minister plans to discuss all of this further. With that, I beg leave to withdraw the amendment.

Amendment 36A withdrawn.

Amendments 37 to 41 not moved.

Amendment 41A

Moved by ***Lord Mawson***

41A: Schedule 2, page 137, line 30, at end insert—

"(d) one voting member nominated by place-based partnerships to represent their collective views in delivering their strategy."

Lord Mawson (CB): My Lords, the noble Lord, Lord Young of Cookham, reminded us last Thursday that we have been talking about the social determinants of health and health inequalities for 40 years. It is now time to act. I want to get practical, and my three amendments are all about the practical detail—the "how" questions—about the transformation of the health culture and about new ways of thinking and working. My focus is on the first small, necessary steps on this journey.

Following my speech at Second Reading, I begin by thanking the noble Lord, Lord Kamall, for agreeing to meet with me and the chairman and CEO of Ashford and St Peter's Hospitals NHS Foundation Trust in north-west Surrey and allowing us to share with him and his colleagues, in more detail, the work that we have been doing there in recent years. This is set out in *Hansard*. This work builds on 37 years of work that my colleagues and I have been doing at the Bromley by Bow Centre in east London on the integration and place-making agenda.

The principles of the work in Bromley-by-Bow are now well known and are being shared with communities right across this country, and this work is now starting to have a national reach, through the Well North Enterprises programme, which I lead. I declare my interests. The work in north-west Surrey is one further practical example of what happens when you start to take these principles to scale and apply them to the place and neighbourhood agenda, which I suggest needs to be strengthened in this legislation.

The Minister thought that it might be helpful to the House if I first set out the background to my three amendments, which are focused on the importance of place and the local neighbourhood, before dealing specifically with the first amendment on the Order Paper. What does a modern integrated health service actually look like, and how do we take the first faltering steps towards it? I suggest that the clues are in the micro: in the place and the local neighbourhood.

The NHS is in some difficulty, and much of the narrative that underpins it is from the last century and now well out of date. The chairman of Ashford and St Peter's hospital describes it as a "financially unsustainable illness service", not a health service. Science and modern understanding of the integrated nature of life and health have, in recent years, taught us a great deal about the social determinants of health. Ironically, the pandemic has forced all of us—the nation, if not the world—to return to the simple question: what is health? Nowadays, we all know that health is no longer simply a biomedical matter for doctors and hospitals—indeed, it never has been. The Peckham experiment on the social determinants of health was telling us all this early in the last century, but the NHS in 1948 thought that it knew better and chose not to continue with this approach.

Health is everybody's business. It is not just the domain of health professionals, hospitals and just one government department. If 70% of the determinants of health are social, and if our present business model for the health service is unsustainable, we desperately need to return to the central question: what is health? What changes to the narrative on services and provisions does the state now need to make to respond to this modern understanding of what health is all about? We need to get upstream towards prevention and early intervention. For this modern generation, which takes integration for granted, the siloed approach of the state will no longer cut it.

Over the last 37 years, my colleagues and I have built practical working pathfinder projects in real neighbourhoods with local people. Others may well refer to these in this debate, so I will not waste the Committee's time now. The Bromley by Bow Centre is in London's East End and is well known nationally and internationally, but we have been involved in other projects. Today, the Bromley by Bow Centre is responsible for 43,000 patients on four sites in Poplar. Working with local partners, we have built the first independent housing company, which is resident controlled and has connected health, housing, education and jobs and business skills. Today, it brings together people from many nations of the world who live there, around practical place-making, health and social projects. This housing company now owns 10,000 properties, owns 34% of the land in Poplar and has in play a regeneration programme worth many millions of pounds.

Today, the Bromley by Bow centre is visited by over 2,000 people from the public sector and across the world, who we find are desperately asking the same questions as us. These are the practical questions—"how" questions—about how we bring together the health services, local authorities and voluntary and business sectors and generate a 360 degree response to people's health needs and lives and the opportunities in local communities. This is not a simple matter, but I suggest that the place to start is not in the macro but in the micro: in local communities and neighbourhoods, where lots of talent and opportunity lie that are not being tapped and never will be if you do not join them up and develop a very different approach.

In 2015, Duncan Selbie, who at the time was CEO of Public Health England, asked me to take this place-making work and the working principles of the Bromley by Bow Centre into towns and cities in challenging communities across the country. In partnership with the NHS, local authorities and business and voluntary sector partners, we created 10 innovation platforms in Bradford, Rotherham, Skelmersdale, Doncaster et cetera. We did not write policy papers or research documents, which, in my experience, often few read; we created practical learning-by-doing environments. The clues that we have found are local—in people and relationships—and not necessarily national.

My three amendments seek to use this legislation to tap into this local talent to take the first steps on the road to integration, with a necessary focus on the local, the place, the neighbourhood and the community. Health is a social matter: it is not just about private individuals, and we now desperately need to get upstream on the health agenda in this country and move forward.

This legislation, and the integration White Paper that is soon to follow, can help us all take the first steps in this century in the transformation of the NHS. I suggest that the micro is the way into the macro; it is not the other way around. In local neighbourhoods across the country, at a human level, we now need to create innovation platforms in local places and neighbourhoods, with public sector leaders and local people willing to support and generate new integrated approaches to health, and learn from them. Let a thousand flowers bloom.

As we expand our work across the country through practical engagement, we are finding that lots of people already get all of this. Many of them are in the public sector and the NHS and are desperately frustrated with the present state of affairs. They want to be health creators, but the system is not harnessing their creativity and energy—so, often unintentionally, it is pouring treacle into their projects and disempowering them, creating an ill organisation.

5 pm

This Bill and the forthcoming White Paper on integration provide us all with an opportunity to start to lay the foundation stones of a new modern health service which understands that health is no longer a matter for one department called the NHS. If what we eat, how we live, whether we have a job, et cetera, is as important—if not more so—than the doctor, this is a matter for every government department. The place to begin to understand what is now needed is local neighbourhoods across this country, to understand the significance of place, neighbourhood and local people and to use this legislation to help us take the first steps along this road.

The three amendments I have put down, focused on place and neighbourhood, are not perfect. This Bill is not perfect, but it might give us an environment to

[Lord Mawson]
harness the energy out there in local communities and generate a health-creating society and a learning-by-doing culture. We need to create a solution-focused culture that is entrepreneurial by nature. The modern world is all about facilitating people and relationships in local communities. This is how entrepreneurial solution-focused communities emerge. It is not about central process, strategy and documents any more. It is not topdown or bottom-up; it is about an inside-out approach. As my colleagues and I have got inside local communities through the Well North Enterprises programme, we have spotted real opportunities to strengthen life and health that the present structures are failing to see.

In my Second Reading speech I set out what is happening in one place in north-west Surrey, where the local hospital, four local authorities, the voluntary sector and the business community are starting to build working relationships and do things together. Health is now everybody's business. The three amendments are not the last word. They are simply an attempt to get this place-based discussion rolling and empower people at the front end in local neighbourhoods and places across the country through this legislation.

I will briefly deal with this first amendment. ICBs must be clear about what a place or neighbourhood is. Neighbourhoods across this country come in different shapes and sizes, be they a place such as Cranleigh village in east Surrey, where my colleagues are working on a new integrated leisure and health campus, with its population of 11,000, or Addlestone, where, with the local authority and health systems in the small town, we are working together on a possible health campus on the street—here, we are looking at 50,000 people. It is not the size that matters, but the local neighbourhood needs to feel real to local people and not an invention of the NHS and the public sector. It must be decided locally.

My professional colleagues in the NHS in north-west Surrey suggest that place-based groups are health and care partnerships at the level of places of a population of about 500,000, encompassing the key providers, which for my colleagues and I means at least NHS-commissioned health providers in that area, including primary care, social care and local government. The neighbourhood is more local and they would work with local partners to agree these. Only those living and working there can possibly know.

The ICS design framework published by NHSEI deals extensively with place-based collaborative partnerships as part of the structure of ICSs, so they are already recognised as part of the structure. For example, on page 23, the framework states that

"as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health."

Their contribution is acknowledged. My proposal is that they are formally recognised on ICBs as voting members.

We suggest that ICBs need to serve the needs of place and be led by a true understanding of health inequalities at a granular level. This can be done only through strong representation of those who are tasked with leading a place and thus come with an appreciation of those needs. This is about ensuring that an appropriate person, with real practical experience of delivering the necessary innovation in local neighbourhoods, has voting rights on the ICB. ICBs need to avoid intervening where it would be more appropriate to do so at a place-based level. Balanced judgment on this cannot take place without voting place-based members with appropriate skill and local knowledge. If the micro is now the way into the macro, this knowledge on the ICB is crucial.

The restructuring of CCGs into emerging ICBs has led to a high proportion of senior ICB posts being occupied by previous CCG officers. Moving to the new model will require new perspectives and behaviours to be introduced. This will require those who can balance a primary NHS commissioning paradigm and culture with one representing communities, the wider determinants of health and a wider range of sectoral interests. In reality, this will likely need to be quite disruptive for a time to achieve the change in approach that is now needed.

Through my discussions with health and care organisations, it is clear that, in aiming to deliver against the aims of the strategy, the details of implementation, procurement, practicalities, working relationships, understanding of local issues, specifics of local organisations, funding arrangements, et cetera, often get in the way of achieving what was actually intended. In setting strategies aimed at improving public health and decreasing pressure on the health and care services, strategies may particularly fail to specify the practical ways in which bringing together broad collaborations of local organisations to work on the social determinants of health will deliver measurable improvements in public health.

The people who work in these individual organisations and are, or will be, part of the place-based partnerships envisaged by the Bill are well aware of these issues of implementation. If the strategies designed by the ICPs are to succeed rather than be frustrated by implementation issues, it is important that they are set within an understanding of these issues. Mandating inclusion of a voting member on the ICB who is nominated by the place-based partnerships—a person of real local experience and track record—to represent them collectively in bringing these implementation details into the design of the strategy will enable better strategy to be set and better connectivity between strategy and implementation, bringing benefits faster to those whom the strategies intend to help.

I apologise for taking so much of the Committee's time on this, the first of my amendments, but I thought it important to set out clearly the rationale behind them, based on practical experience on the ground over many years. I beg to move.

Baroness Cumberlege (Con): My Lords, I support these amendments and I especially support the noble Lord, Lord Mawson. It was typical of him that he started our thinking about what health is; I am sure there are many answers, but I think one of them might be integration—not just integration on the biggest scale but in terms of neighbourhoods, communities

and what we now call place. That is so important. Those are the building blocks of all we are trying to do in the hierarchy of the National Health Service.

I am inspired by the noble Lord. He is a man of infinite resource and sagacity, an entrepreneur and, above all, a great achiever, based on solid principles which he believes in and, like a man of the cloth, is anxious to spread to others. He does so with really good effect.

It is no accident that I entitled my first report to the Government, many years ago when I was Mrs Cumberlege, *Neighbourhood Nursing: A Focus for Care*, as I believe the neighbourhood—or, in today's parlance, the place—is all-important. This is what colours how people think, behave, succeed and, sometimes, fail. The noble Lord, Lord Mawson, has shown how even the most deprived areas can be rejuvenated and thrive with strong leadership, purpose and commitment. The noble Lord's deep unshakeable philosophy is that patients, people and the local community should be the movers and shakers and be in control.

I want to mention Bromley by Bow, because it was a really innovative and new way of thinking about things. I remember visiting it years ago, not quite when it first started but when it was beginning to really thrive. Bromley by Bow was the first health centre in the country to be owned by the patients. Founded in 1984, it began with just 12 elderly patients, a rundown church, and just £400 in the bank. Today, by applying entrepreneurial principles to challenge social and health issues, it now has more than 250 staff. It is responsible for 43,000 patients, as the noble Lord said, and four health centre sites across Poplar. It operates on 30 sites even more widely across east London. It has supported local entrepreneurs. What is really interesting is that it has built 93 small and medium-sized enterprises. This is people helping themselves and ensuring that there is employment through a charitable structure, a housing company, which is controlled by the residents and now owns 10,000 properties and 34% of the land in Poplar.

This is a remarkable achievement in a very poor part of London. It is effective because it recognises that health and wealth are profoundly connected—not in huge municipal buildings and ivory towers remote from their populations but by the people who live and work in that area. The schemes are intertwined with the population. They are neighbourhood schemes and recognised as such. They are valued by being part of the destiny of a place in which local people live and work.

I visited Bromley by Bow in the early days, as I said, and I am really disappointed by my GP practice in the village in which I live and grew up. My father, one of two GPs, knew his patients literally inside and out. He knew who was getting off with whom. As his children, the first thing we learned was confidentiality and how to respect it, because we heard all sorts of things. He managed to get a health centre built. It is called that: above the entrance to the building it says, "The Health Centre", but today it has been renamed the medical centre. It is a service that is not about health but about transacting to patients what the doctors think they need. The practice even shuns social prescribing, which is prevalent in many areas. It is also very careful not to involve the community. The friends of the health service have become disillusioned. They were established about 20 years ago and they are fed up with what is going on. Two weeks ago, they closed that organisation.

The noble Lord, Lord Mawson, in his Amendment 41A seeks to use the new world of integrated care boards to ensure that local representation is guaranteed. We have had a lot of debate in this Committee about who should be on what board and so on, but in listening to those debates—there was a big one last Tuesday—I was very struck by people talking about the big battalions. I could see that people were trying to ensure places on the integrated care boards that were represented by the big battalions. That is understandable. They are the component parts of the NHS. There are parliamentarians who see this as the only way forward.

5.15 pm

The noble Lord, Lord Mawson, has shown us other ways, but it is a struggle. Today, the Bromley by Bow Centre has to deal with far too many sources of funding from the public sector. The money from the Treasury is disbursed to the silos: education, local government and other agencies. The centre spends too much time trying to put it back together again to deliver integrated projects. The centre runs hand to mouth, even after all these years, because mainstream funders in government do not recognise what the centre actually does. Schools, treatment centres, tertiary colleges, hospitals and traditional health centres are well understood, but Bromley by Bow does not fit any of these traditional silos.

I welcome the amendment and the others that follow it. The noble Lord is trying to free up the claustrophobic, traditional ways of not only working but, equally importantly, thinking. But the dilemma we face is this: warm words are given that we must not stifle innovation, but innovation is challenging. It is uncomfortable. When Henry Ford was describing his new invention, the motor car, he asked the public what they thought of it and what they would like. The reply he got was, "Just give us faster horses."

We have a serious dilemma, as big government departments, especially the Department of Health, are about providing the same standard of health and the same provision across our nation. Again, we have a debate on that concerning Scotland, Wales and Northern Ireland. But even the nation grumbles as soon as it perceives a postcode lottery appearing.

Trying to square this circle is really difficult. The department seeks change through laborious systems. Those are the tools it has. Big departments deliver to the nation through their own power lines. This amendment threatens a short circuit that might set the structure alight or give the department an electric shock. That is no reason not to try. People of stature and proven trustworthiness who are competent and prepared to take responsibility for their innovations and to report to the department, say, every two or three years an audited evaluation of the scheme's progress and outcomes, should be supported. It might help to square the circle, because if the funders of public money have to be accountable, this is one way of doing it.

I support not only innovation but these amendments. I urge both Ministers to risk their all: to let new ideas for places in need, through special workable collaboration,

[Baroness Cumberlege]
have their head. If we want to level up, then let us be brave and let sparks fly, because it is time to get behind people with a proven track record who are entrepreneurial, not people who talk and write reports about it.

The noble Lord, Lord Mawson, has taught us that the future is about creating a learning-by-doing culture, as he mentioned in his introduction. That is the culture that we want in the NHS, where the whole system learns through best practice on the ground, in real places with real people. Where things are not working, let people such as the noble Lord intervene and turn problems into opportunities. He has spent his life doing just that.

Seeing is believing. I encourage my noble friend on the Front Bench to visit Bromley-by-Bow, as a past Minister, Sir Brian Mawhinney, did. He ensured the future of this enterprise for a few more years and enabled it to flourish. I know that ministerial diaries are a real challenge, having had one, but I assure my noble friend that a visit to Bromley-by-Bow will never be forgotten and will make a deep impression.

Baroness Thornton (Lab): Might I have some clarification from the noble Lord, Lord Mawson? He and the noble Baroness, Lady Cumberlege, have referred to three amendments and I can see only one. I would be grateful if he could enlighten me on which the other two amendments are that we might be addressing in this debate.

Lord Mawson (CB): My Lords, there is just one amendment in this debate. My other two come further on.

Lord Clement-Jones (LD): My Lords, it is a huge pleasure to follow the noble Lord, Lord Mawson, and the noble Baroness, Lady Cumberlege. I have signed and strongly support all the amendments tabled by the noble Lord to ensure that integrated care boards are closely connected to local communities. We have riches yet to come: the noble Lord's later amendments ensure that local solutions are prioritised, and that procurement is firmly rooted in local communities, but I will speak only to Amendment 41A.

I will give an example of when the noble Lord and I have been involved in another project, beyond the very important Bromley-by-Bow project that the noble Baroness, Lady Cumberlege, talked about; namely, the St Paul's Way Transformation Project, the health, education, jobs and skills, and community campus which started in 2006. It is a great example of a response to the local challenges faced in an east London neighbourhood very close to Bromley-by-Bow, with failing health and education services and community relationships. This transformation project was focused on integration from day one and has been a huge success.

The noble Baroness, Lady Cumberlege, talked about the extraordinary track record of the noble Lord, Lord Mawson, as a social entrepreneur. He launched this project in partnership with the NHS and Tower Hamlets Council, and brought together the local authority, the local school, the GP network, the local housing association, Poplar Housing and Regeneration Community Association, and the diocese of London, to bring about transformational change in and around St Paul's Way, a main street running through Poplar. Together they built a new secondary school, new primary school, new health centre, new mosque, new community centre and restaurant, new park, new street scene and 595 new homes. In parallel with this, the quality of the local leadership, and hence of local service provision, was transformed. The failing secondary school moved to Ofsted outstanding, the failed GP practice was replaced and its successor became CQC outstanding, and the independently monitored residents' satisfaction level is currently 85%.

The St Paul's Way project has been a great success story of local partnership with other local actors. For example, near neighbour Queen Mary University of London, the governing body of which I chair, with two campuses in Tower Hamlets, and which is intimately involved in the governance of St Paul's Way Trust School, helped design and develop the school's new science labs. They are in the health building, which the school uses and where we have taken space for our school of dentistry and DNA research.

Partners in the local schools, the GP practice and the housing association have played an important role in recent years, as they have shared their work and experience with communities in towns and cities across the north of England and now beyond. However, the project faces major challenges, as outdated NHS procurement systems are now in danger of undermining the good work that it has been doing for over a decade. Amid this project being put together, the PCT procured a primary healthcare provider with no London experience, let alone any local experience. After two years, it surrendered the contract because it had not understood that primary healthcare is very different and costs a lot more to deliver in Poplar than in affluent suburbs. This experience is an illustration of the importance of there being a neighbourhood voice in the making of decisions by the NHS, which, if they are got wrong, can damage the ability of local integrated partnerships to function and develop effectively at the neighbourhood level. There is an opportunity to address this in legislation.

In this light, how can the Government make integration a reality? This is a clear example of disconnects that will be replicated on other streets across the country, and a demonstration of what happens when the NHS procurement systems and policy do not take place and neighbourhood seriously. Health is about bringing people and communities together, not undermining them. The solutions are often local and not in large outdated systems and processes. This local approach must be embraced. It is at the 50,000-person neighbourhood level, not an enormous eight-borough ICS where integration aimed at innovation in prevention and recovery can be most effective. Neighbourhood must be understood, valued, and given leverage in the system and flexible use of budgets. It is at this level that the actual practical interventions can happen. It is here that schools, housing, job opportunities and community action can happen. Neighbourhoods can act with speed and agility.

The noble Baroness, Lady Cumberlege, suggested that the Ministers visit Bromley-by-Bow; equally, I suggest a visit to the St Paul's Way transformation project. This amendment is as much about creating

the right culture as the right representative structure. I hope that the Government accept this important amendment and the other amendments tabled by the noble Lord, Lord Mawson, on this subject.

Baroness Andrews (Lab): My Lords, I too was very happy to sign this amendment. I will speak only to it. I congratulate the noble Baroness, Lady Cumberlege, on her very moving speech, and the noble Lord, Lord Mawson, on a very comprehensive speech. I will be brief. In view of the logic of everything that I have heard in debates on previous amendments this afternoon, this amendment is even more important than I thought. When the Committee is discussing how to make the ICBs as effective, powerful, salient and comprehensive as possible for the people that they are bound to serve, all these factors must be taken into consideration, but the power of place itself and the opportunity that the ICB creates to make this manifest, just as the noble Lord, Lord Mawson, has made manifest in Bow, is a unique and highly innovative opportunity, and one which may not come again.

What the noble Lord proposes is extremely modest. It is to give just one person from the partnership voting power. However, it is essential, and it is in the spirit and the logic of what place-based partnerships are intended to do. It means that on the ICB there will be people who can bring nearsight, access and reach into the community to the decisions of the ICBs. They can help to inform those decisions, to bring that knowledge and sensitivity of the lives that people live, what they are faced with, and their specific choices. They are one of the most optimistic partnerships and ideas that we have had in this House for some years.

I have spoken many times in this House on the power of place, what it can achieve and how it affects people's lives, particularly their health. The noble Lord, Lord Clement-Jones, and I published quite a useful report on building better places when we were on the same committee a few years ago. We diagnosed the relationship between good design, good buildings, good environments and good health. Maybe it is time to get that back off the shelf.

What is also useful is that the partnership principle is alive and well and is generating good practice. There is increasing evidence that it works and that there is an increasing exchange of ideas and skills, and we are learning all the time about what is possible. There is nothing to be said against this.

5.30 pm

The expertise that the partnership can offer to the ICB may come from different partners. I am particularly interested, for example, in the role that housing providers could have, and I am sure the noble Lord, Lord Best, will speak to this in his amendment. They will bring a perspective from the point of view of the tenant, and the diseases of poverty in poor housing, which the board will need to hear, and act on.

Equally, there could be a role for mental health providers who know why young people cannot access mental health support. They know where the bottlenecks are, and what is needed. The partnership will choose for itself who will represent it, who has the most effective voice and who knows the place, as has been said this afternoon. But the essential criterion is that they know what will be delivered best.

I hope noble Lords will indulge me for a moment as I share a bit of history, because this has a very long history. In 1889, Charles Booth in his maps in *Life and Labour of the People in London* literally mapped disease against places and housing conditions—the stews of London—in a graphic illustration of where the worst concentrations of poverty were. In so doing, he redefined both health and poverty. Significantly, the first evidence came from the school boards and the local policemen: real partners in place. He certainly understood that you could not reduce inequalities or promote good health unless you had decent housing, fresh air and a decent wage. The geography of poverty has not changed that much—it is still the geography of disease and premature death—and the prescription has not changed at all. This amendment is an opportunity to put that into immediate and direct practice.

I hope that the Minister does not need much persuasion on this. It is a very simple and a very necessary amendment, and he would certainly have the support of the Committee in entertaining it.

Lord Crisp (CB): My Lords, I declare my interest as an adviser to Well North Enterprises, which was mentioned by the noble Lord, Lord Mawson. I congratulate him, and other noble Lords from different parts of the House who have spoken on this amendment, on making the whole issue extremely clear.

I will make a few very specific points. First, we have heard about great big projects making a massive different. Everyone in your Lordships' House, I am sure, knows of smaller examples that are making a real difference, as well as the larger examples, and how the small examples are important and add up.

Secondly, this is about change happening locally, but it is also about what is happening globally. I have previously quoted, in this House, a saying by a friend of mine, who used to run the Ugandan health service, that "Health is made at home, hospitals are for repairs". It is a powerful expression, and one might say that health is made at home and in the community, and in the workplace and in the school. It also contains the notion that health can be created; it is not just about preventing disease.

Noble Lords may like to know that, more recently, globally, the WHO published the Geneva Charter for Well-being at the end of December, which explicitly talks about the creation of a "well-being society". So this is a global movement we are talking about, not just a local one—although, as the noble Lord, Lord Mawson, has continually emphasised, this is about the importance of practical changes at the local level.

I will make two final points. The big one is that when we think about the membership of the ICBs, it is important we have the insiders there—the clinicians and the people who know how the systems work—but we also need some outsiders there. Referring to the debate on the last group, this is not just about different skill sets; it is about different behaviours and doing different things in different ways. Those of us who

[Lord Crisp]
have worked within the system are bound by the system and think in terms of the system and its regularities.

The sort of people the noble Lord, Lord Mawson, is talking about do not start by thinking about the system; they start by basing things on relationships and learning by doing—a point that he emphasised. So there are different ways of doing things, and it is important that, as these boards are constructed, they bring in people with that different approach, alongside the great knowledge and skill that NHS and other clinicians bring to this. I know that we will really achieve success by bringing together insiders and outsiders, and getting people working together and understanding how to do things.

My final point is that this amendment proposes having a person representing or drawn from these groups on the ICB. I recognise the debate that has been going on about tying the hands of local people about what is happening on these ICBs. I understand that as these things get larger not only are you including more voices but also, implicitly, you are including more vetoes. The health service has, over the years, suffered from having too many people with too many vetoes in terms of making change happen.

I understand the complexity and difficulty here, but the final part of my point is to ask the Minister a question. I asked him a question earlier, because—I do not know whether I am alone here—I am not sure that I understand how, in reality, all these bits will fit together and work together in this new structure. I know he committed, in an earlier part of the debate on the Bill, to providing us with a diagram and perhaps more of an explanation of how it will all work. I can see how the complexities of everything we are talking about here can be difficult.

The single point I want to reinforce is the importance of not just having insiders in the decision-making process, but also having more disruptive influences. It is not just about skill sets; it is about different ways of thinking and behaving, and a focus on relationships, not just on systems.

Baroness Harding of Winscombe (Con): My Lords, I also rise to support the noble Lord, Lord Mawson, in his amendment, and congratulate him and his colleagues on the extraordinary work they have done.

I support the Bill precisely because integration will be key to delivering the health outcomes that we all seek. But I worry that, if the Bill is just rearranging the organisational deckchairs, with exactly the same people in different organisations with different three-letter acronyms, we will not change anything at all.

I think that, over the course of the nearly three days we have spent in Committee and on Second Reading, there is cross-party agreement on the nature of the problem we are trying to solve. In each debate we have had over the last two and a half days, whether on health inequalities, mental health, the social determinants of health, or person-centred digitally enabled care, there has been extraordinary cross-party agreement on the nature of the problem. As the noble Lord, Lord Clement-Jones, said, we are debating and disagreeing more on the means to the ends than anything else.

One of the means to the ends is local—genuine local ownership and leadership. Like many in your Lordships' House, I have made the pilgrimage to Bromley by Bow and I have also been to St Paul's Way. When I first joined the NHS, about five years ago, I was told to go to Bromley by Bow, and I was told by a number of NHS insiders how brilliant it was, but how impossible it was to replicate anywhere else. "Go and have a look at it, Dido," they said, "because you'll be amazed and impressed, but no one's worked out how to spread it".

What I have actually discovered, as we have heard today from people with far more experience of place-based leadership than I have, is that brilliant though Bromley by Bow is, it is not alone. There are fantastic place-based leaders in communities across the country. It is those local groups and leaders who we owe the exit from Covid to more than anyone else, I suspect.

I have had the privilege of working alongside them. I have been to north-west Surrey with the noble Lord, Lord Mawson, but also to Wolverhampton, to the Guru Nanak Sikh gurdwara, one of the first local testing sites for NHS Test and Trace. I have been to Gloucester and spent time with Gloucester FM, a local community radio station that for the first time in its existence got funding to run an advertising campaign to encourage people to come and get vaccinated in the local community. That was the first time it had succeeded in working collaboratively with the local NHS.

I have been across the country in the last two years talking to people from groups who feel excluded. Whether it is the Roma Gypsy community, Travellers, refugees, taxi drivers or faith leaders from a whole host of communities, all have told me—in both my previous role as chair of NHS Improvement and as executive chair of NHS Test and Trace—how in different ways they felt excluded not just from the NHS but from society in general. They also said, generally to a man and a woman, how hard the NHS is to work with when you are from a small, outside local group, as those of us who have worked in the NHS know.

It is with that knowledge base that I wholeheartedly endorse the spirit of the amendment of the noble Lord, Lord Mawson—but with a "but". I have been consistent in the last two and a half days of Committee in being nervous about adding specific roles and experiences to what is now a growing list of characteristics and past experience we would all like to see in this new three-letter acronym NHS entity, the integrated care board.

I would like to post a question to the Minister. It is clear that we need these local voices—the grit in the oyster, as my noble friend Lady Cumberlege described it; the difference that the noble Lord, Lord Crisp, is referencing; people from outside the system—if this new reorganisation is going to be anything more than a rearranging of the deck chairs. How will we ensure that those local voices are genuinely heard in an integrated care board?

Lord Kakkar (CB): My Lords, I rise to support the amendment in the name of my noble friend Mawson and others, and in so doing congratulate him on his thoughtful introduction. It is clear that one of the most important aspects, and the purpose, of this Bill is

to ensure integration at a local level. But the purpose of that integration must surely be—as has been confirmed by the Minister—to improve health outcomes for the entire population. It is well recognised that that can happen only if the social determinants of health in local communities are addressed appropriately and effectively, in a way that our health system has not been able to do to date.

If we accept that to be the purpose, then local integration—that focus on and understanding of the social determinants of health—and responding to local needs must be secured in the organisation of the integrated care systems and their boards. As we have heard from the noble Lord, Lord Mawson, and others, to achieve that, one must not only understand, appreciate and hear the local voice, but be clear that the culture that is established in these systems is responsive to those voices and is determined to act on them and the understanding of the local situation—particularly those social determinants that extend far beyond what has been and can be delivered through healthcare alone—and focus on other issues such as housing, education and employment. It would be most helpful if the Minister, in answering this debate, could explain how that is going to be achieved in the proposed construction of the integrated care boards.

Of course, one recognises that Her Majesty's Government are deeply committed to this agenda. But it is clear that if these boards are not constructed in such a way that they can change the culture and drive, in an effective and determined fashion, a recognition of those social determinants and create opportunities at a local level to address them, much of the purpose of this well meant and well accepted proposal for greater integrated care at a local level will fail.

Lord Lansley (Con): My Lords, I did not originally intend to contribute to this debate. However, I would like to thank the noble Lord, Lord Mawson, for his Amendment 41A, which, although modest in scope, has initiated an extremely useful debate and raised a lot of important issues. I do not want to add a lot of material to the debate, but I want to focus on the questions that have emerged from it.

5.45 pm

It will not surprise noble Lords to know that I have been to Bromley by Bow, as shadow Secretary of State, and as Secretary of State in the company of Sam Everington, now Sir Sam, who was and is an advocate for clinical commissioning. I put on the record that we must not lose sight of the value of clinically-led commissioning in delivering best-quality outcomes in healthcare. I do not think it is the Government's intention to lose that, but we need to make sure it is not lost sight of.

Taking the example of Bromley by Bow, where did it get to? It had the Tower Hamlets clinical commissioning group, which was once CCG of the year, an exemplar in this field. That CCG and others eventually came together in a large conglomerate operation—I think the noble Lord, Lord Kakkar, will know it very well—the seven CCGs in north-east London. A population of about 2 million eventually came together in one large organisation.

We started out with clinical commissioning groups whose understanding was that they need to work with local authorities through the health and well-being boards. They needed additional powers for the integration, which is absolutely fine. But as I said on Second Reading, we have ended up with the NHS and its management getting themselves in a terrible twist in terms of organisational structures and geography. The noble Lord, Lord Mawson, talked about place-based partnerships with a population of half a million. The noble Baroness, Lady Cumberlege, talked about place and localities with a 50,000 population. My point is that the 2012 legislation, even if it did not achieve what was intended, at least said that clinical commissioning groups could determine whatever population they like—they could set it at whatever level made sense. They ended up with about 300,000, on average, but the range goes from 30,000 to 800,000.

I do not think we should get obsessed with geography. We should still, even at this late stage, be letting the ICS achieve what it needs to by being a relatively large organisation with the capacity to do population health management and to manage commissioning at a higher level. Going back to what my noble friend Lord Hunt of Wirral said, it should be bigger—this is the key to why size matters—in the jungle than the big provider trusts, making sure that conflicts of interest do not arise and the providers do not run the commissioning. But then, if you have a big ICS, there is a big gap. How is place and local leadership going to be incorporated? The noble Lord, Lord Mawson, rightly talks about it being represented on the integrated care board. But where is it in the Bill? I know that NHS England, NHS Improvement and the Local Government Association have produced guidance and referred to place-based partnerships being an integral factor in the Bill. But I do not see it in the Bill. It is not there. How are we going to put it in the Bill? How are we are going to make sure it happens? How are we going to achieve the objective that the integrated care boards genuinely integrate health, social care and the whole range of those services, which in my view is what they should do, in order to deliver health?

The integrated care partnership, incorporating health and well-being boards, should be about achieving the social determinants of health. I depart from the noble Lord, Lord Kakkar, in that I do not think it is the job of the health system to deliver the social determinants of health. It is the job of government to deliver the improvement in well-being and health that is implied by moving in the right direction on the social determinants. The integrated care partnership is where that should happen.

I see no reason why the clinical commissioning groups cannot be a place-based, clinically led basis for creating place—they are going to be abolished, but in that sense, why are we doing that, since they already exist? Secondly—to repeat a point—health and well-being boards to my mind are the basis for creating an integrated care partnership that is the essence of well-being. That seems to me a much simpler structure. I was accused a decade ago of making it all too complicated; it is now at risk of becoming even more complicated. Let us at least start with what we have, which is exactly what they did in north-east London. They came together

[Lord Lansley]
and said, "Look, for the three boroughs of Newham, Tower Hamlets and Waltham Forest we can create something that is large enough to work, and inside it we have the borough-based relationships which are the method that we ourselves apply locally to deliver the health and well-being that we hope to achieve".

So I ask my noble friend, at this stage—as we are just starting out on this—whether he would be kind enough to show us where in the Bill the essential element of place is to be inserted. Then we can debate it further and put it into the Bill in its right form.

Baroness Thornton (Lab): I thank noble Lords for what has been a very interesting and important debate. I thank the noble Lord, Lord Mawson, for his amendment, and I look forward to further development of the thought process that he has put before the Committee. Of course, it is not new. I started my working life working for Michael Young, the great sociologist in Bethnal Green, and we talked about ethnographic research in our neighbourhoods and places. It was about giving people who lived in those places power and developing their own leadership of what they wanted to happen. Of course, in those days, when he started doing his work, it was about regenerating inner London—the bomb-strewn East End. I had the great privilege of running the Young Foundation: a few years ago, I took a couple of years off from this job here to go and run it, and we were doing exactly the place-based work that the noble Lord, Lord Mawson, talked about.

The noble Baroness, Lady Harding, is completely right: there are many Bromley by Bow-type programmes across the country—and thank goodness for that. If the Minister decides to go on trips to places, Bromley by Bow is of course important. I went there when it started out, when I was the founding chair of Social Enterprise UK, and the noble Lord, Lord Lansley, is quite right: it is brilliant, it is wonderful, it does great work —but why has it not been replicated? That is a question I have discussed with the noble Lord, Lord Mawson, on and off over many years. But there are many other types, and I suggest that the Minister might go to Manchester, Bradford or Nottingham, where there are some brilliant programmes where this place-based delivery of healthcare and other care is thriving.

The consensus breaking out between myself and the noble Lord, Lord Lansley, is of course that this Bill is an opportunity: how and where in the Bill can that place-based initiative be expressed? Where is it and how can it be encouraged? The King's Fund did a piece of work developing place-based partnerships as part of the process leading up to the Bill, which was published last year. It has some interesting and useful things which express the sorts of sentiments—but in NHS-speak—that the noble Lord, Lord Mawson, talked about today: the importance of connecting communities, jointly planning and co-ordinating services, making the best of financial resources, supporting the local workforce, and driving improvements through local oversight and quality provision. There are certain elements of this which need to be there and need somehow to be built into the Bill, possibly in enabling form, because they mean building multiagency partnerships which involve local government, NHS organisations, voluntary service organisations, social enterprises and the communities themselves.

The noble Lord, Lord Mawson, rightly asks in his amendment for one voting ICB board member to be nominated by place-based partnerships. That may or may not be a good way forward, but we are trying to do systems change and, whether or not putting one person on a board is the way to do that, it is a very good place to start. So we on these Benches are very interested in how this develops and want to be part of the discussions across the House about how we do that.

Earl Howe (Con): My Lords, no one is better placed, whether inside or outside your Lordships' House, to advocate place-based partnerships than the noble Lord, Lord Mawson. I know he will remember that one of my first visits as a Health Minister in 2010, at his invitation, was to Bromley by Bow. What I learned that day made a deep impression on me, so I, like many noble Lords, need no convincing of the case that he and other speakers have made today.

I am aware that the noble Lord, Lord Hunt of Kings Heath, has tabled Amendment 165 on place-based arrangements, to be debated by this Committee later in our proceedings, so no doubt we will cover the issues in more detail then. For now, I say that the Government absolutely agree with the importance of having strong place-based elements in ICBs. Place-based structures will play an important role in delivering healthcare services for their population groups and we expect there to be open and clear lines of communication between the board of the ICB and place-based structures.

How is a sense of place given—as it were—tangible substance and meaning? I would argue that we do not necessarily need the Bill to articulate the reality. At a very basic level, an ICB will cover a geographic area. We would expect ICBs to be closely linked to their places via bodies such as health and well-being boards, where they will sit as the successor bodies to CCGs, and local authorities. ICBs will sit on the integrated care partnership as well as the health and well-being boards. Both bodies are vital in bringing together health, social care, public health and, potentially, wider views as well. That will be part and parcel of delivering their duty to involve patients, carers and the public when discharging their functions.

We expect ICBs to have place-based structures in place, but we do not want to prescribe what those structures are. As the noble Lord, Lord Mawson, said himself, we do not want ICBs to think that place-based partnerships are achievable via a central blueprint, or that a set of instructions from above is likely to be a substitute for learning by doing and local relationships. What we shall insist on is that an ICB sets out the arrangements for the exercise of its functions clearly in its constitution. Different areas have different needs, and I hope it is a point of agreement across the Committee that a one-size-fits-all model would not be appropriate.

6 pm

I heard what the noble Lord, Lord Mawson, said about the need to join up strategy with implementation and having an individual whose job it is to oversee this.

That may often be the way that ICBs choose to go, but we feel that requiring voting rights for place-based partnerships is simply not necessary and would come at a bureaucratic cost. Our view is that we should not attempt to overlegislate for the composition of ICBs. Instead, we should let them evolve as effective local entities to reflect their local needs. I hope the noble Lord, Lord Mawson, will forgive me for not wanting to pepper the Bill with requirements and duties for ICBs. If we want to make a thousand flowers bloom, I do not think this is the way to achieve that. I fear that the amendment would risk making the boards less nimble, undermining their ability to make important decisions efficiently.

Having said that, I am not at all suggesting that the centre should wash its hands of this agenda. In answer, in particular, to my noble friend Lady Harding, NHS England will be keeping a close eye on the constitutions of ICBs, and we expect the assessment that NHS England makes will include whether there are suitable place-based structures and whether there is clarity about the expectations and roles of those structures, including what they are responsible for commissioning, what powers have been delegated to them and what resources they are responsible for.

With those points in mind and looking forward, as I say, to our further debates on the subject, I hope that this assures noble Lords that the Government have this agenda very firmly in their sights and that NHS England has equally. Therefore, I hope that the noble Lord will be able to withdraw his amendment, in the knowledge that I am sure we shall have further things to say on this important subject.

Lord Mawson (CB): My Lords, I thank the Minister for those thoughts and comments. I also thank noble Lords who have supported this amendment and this very encouraging debate. The purpose of today was to open up a discussion about these issues. They have been very well aired and I think the discussion needs to go further. Certainly, I would like to take further with the Minister and his colleague the discussion around the implications. My concern is to ensure that the significance of place and neighbourhood and that the role of the micro is absolutely clear at an ICB level. Senior colleagues in the NHS where I am working warn me to be very careful about this. The danger is that fine words will be used, but as others have said, this is not about words; this is about understanding the actions that now need to take place to really transform the health service. The micro and the macro need to learn to dance together, and that will not happen unless there is greater clarity on it. It has been a helpful conversation and one that I hope will be taken further.

I have a few final thoughts. It has been good to have colleagues from different parties and very different backgrounds in this discussion, which I have found very helpful. This is not a party-political matter; this is about the next 20 or 30 years of the National Health Service. There are likely to be different Governments and different parties with responsibility, but laying the foundation stones correctly and getting the detail right—it is all about the devil in the detail, in my view—is really important.

It was very interesting to hear bits of the history. It was Lord Michael Young who came to see me, many years ago, in Bromley by Bow, precisely because he got very interested in what we were doing. It was not just that he joined us as a community and became our patron—we have had patrons from different parties; Lord Peyton from the Conservative Party was a patron for many years, as was Lord Ennals from the Labour Party. Lord Young ended up asking me to marry him and his new wife. I had to do the marriage, and eventually the baptism of his child, so there is a long history. Allison Trimble, my former chief executive, was called to work in the King's Fund precisely to help it understand the devil in the detail of what we were discovering, so this debate brought back many memories for me.

One of the last few things to say is that it is important in this journey that we create a learning-by-doing culture. This culture is very well known to science. In part of my life, I work with Professor Brian Cox, who knows a thing or two about science. I think the reason we get on is that we both understand that science and entrepreneurship are profoundly connected. It is not just the health service, in my view, but the whole public sector that needs now to embrace a learning-by-doing culture that moves beyond strategy and process into learning from the practical things it does and does not do.

Finally, I thank Suzanne Rankin, the chief executive of Ashford and St Peter's Hospitals, and the chairman, Andy Field—Suzanne is a brilliant chief exec and Andy is a rather excellent chairman—for joining in this conversation with the Minister. I also thank colleagues from the hospital, who I think we would agree have been very brave, and who have now, with four local authorities, set out on a journey to lead the way in Surrey on what this might mean when you start to move it to scale. Having said that, I beg leave to withdraw the amendment.

Amendment 41A withdrawn.

Amendment 41B not moved.

The Deputy Chairman of Committees (Baroness Fookes) (Con): We come to Amendment 42, where the noble Baroness, Lady Masham of Ilton, will be taking part remotely.

Amendment 42

Moved by ***Lord Hunt of Kings Heath***

42: Schedule 2, page 137, line 43, at end insert—

"(7) The constitution must provide for one non-voting member to be appointed by the local healthwatch organisations whose areas fall wholly or partly within the area of the integrated care board."

Member's explanatory statement

The amendment provides for local healthwatch organisations to be represented on integrated care boards in a non-voting capacity.

Lord Hunt of Kings Heath (Lab): My Lords, I have a number of amendments in this group concerning Healthwatch and, although it is important, I shall attempt to be brief.

[Lord Hunt of Kings Heath]

We debated this, of course, in the Health and Social Care Bill 2012. I remember the noble Lord, Lord Patel, led a debate in which he called for the national Healthwatch to be made independent. He said then that embedding Healthwatch in England in the CQC was a mistake. I agreed with him then and I agree with him now. I would argue to the Government that there would be a big advantage in making Healthwatch fully independent. Of course, I am also concerned about local Healthwatch, to make sure it has enough influence in the new system as well.

It is right to pay tribute to the work of Healthwatch. I think it has done a good job since it has been established. Recent reports of national Healthwatch have been about access to dental care, on which I have an Oral Question in a week or two's time. It undertook a very interesting analysis of the Government's social care plans compared with proposals, and compared that with what people had told Healthwatch would make social care better.

Locally, my own Healthwatch in Birmingham has done some excellent work. I particularly mention a recent report on digital exclusion during the pandemic, when there was a sudden shift—like everywhere—towards remote access to care. Birmingham Healthwatch identified five principles for post-Covid-19 care, to ensure that everyone has access to the appointments they needed. This included a commitment to digital inclusion by treating the internet as a universal right. I believe its work has contributed more generally to the way in which this is being taken forward in the system. I think that, under the circumstances it has been operating in—not without difficulty and not without some tensions with local authorities—it has made a good start.

I want to just push Healthwatch on a little further and I want the Government to help. First, I am absolutely convinced that national Healthwatch should be an independent body. I have never understood the thinking that it should be a statutory committee within the CQC. I assume it is because, at the time, the Government were going through one of those wearying bonfire of the quangos that all Governments go through before they set up new quangos, to then have another bonfire a few years later. It just makes no sense. Clearly, they have complementary roles, and I am sure that the CQC takes note of what Healthwatch says, but they are different roles: one is the statutory regulator; the other has a responsibility for raising issues on behalf of the public who use the health services.

The question then arises of how we can strengthen Healthwatch at the local level. Will the systems, the integrated care partnerships and integrated care boards, listen to what Healthwatch has to say? A recent survey of ICS leaders—all there, in position—for Healthwatch England and NHS England shows that 80% would support Healthwatch having a formal seat at the table of the ICB if it were set out in legislation or guidance. What about the other 20%? Should it really be down to the vagaries of local leadership to exclude Healthwatch from those local bodies? I really do not think so.

I do not know if the noble Earl, Lord Howe, in answering, is going to be of a centralist or localist philosophy, or both, but it is always interesting to discuss. He and I have been discussing NHS structure for some 25 years now, and somehow the arguments tend to go on. It would be a real advantage for boards and partnerships to have Healthwatch around the table. It need not have voting members—indeed, I do not think it should. It is doing incredibly good work and has not been given enough publicity or recognition by people in the NHS. This surely is a way in which we can do this.

The Government also need to look at the budgets of Healthwatch England, which is going to have to support extra work and will need to be given more resources. Through local authorities, we need to make sure local Healthwatch has enough resources to deal with the pressing issues and challenges it is going to face. Having said that, our job today is just to encourage national and local Healthwatch to build on what they have done. I hope we can do this in as positive a way as possible. I beg to move.

The Deputy Chairman of Committees (Baroness Fookes) (Con): The noble Baroness, Lady Masham, is now able to speak and I invite her to do so.

Baroness Masham of Ilton (CB) [V]: My Lords, I am pleased to see that the noble Lord, Lord Hunt of Kings Heath, is taking part today. He has been involved in a family emergency, which shows how important grandparents are in the care of children.

I have added my name to some of the amendments in this group but support them all. The Bill will be improved if the patient voice is included in both the integrated care boards and integrated care partnerships by Healthwatch, which could collect data from different sources representing patients. There should be co-operation and working together throughout the NHS, co-operation with the CQC and better integration throughout so that standards are kept high across the country.

The recent report, chaired by the noble Baroness, Lady Cumberlege, *First Do No Harm*, also demonstrates how important the patient's voice is. As Healthwatch is spread so thinly at the moment across England, it will have to be bolstered so that it can do the job. The Bill should set clearer expectations for local systems on the need to use the views and experiences of their local communities to inform decisions. The aim is to establish Healthwatch as an independent body rather than a sub-committee of the CQC. The voice of patients will provide so much first-hand experience, and public involvement is so important to help improve standards throughout the country.

Patients can highlight good experiences and services that need improving. Often, communication needs improving, as does hospital food, which differs across the health service, waiting times, late diagnosis, ambulance provision and many other concerns. Many patients want to give something back to the health service when they have had to use it. Being a dedicated member of Healthwatch could be a solution. I hope the Government will appreciate the benefit of the public working with them rather than against them.

6.15 pm

Lord Patel (CB): My Lords, I am glad to see the noble Lord, Lord Hunt, in his place. I welcome him back and am pleased to hear that things are good with his family. As he mentioned, in 2012 I led on the amendment

arguing for Healthwatch to be made independent. I did not succeed—it was defeated by 22 votes—but we had a coalition Government at the time, so I did not stand much chance anyway. I will try again today.

My name is attached to all the amendments in this group. They are the key amendments relating to local and national Healthwatch, and they address public and patient involvement in the Bill. The Bill says a lot about how patients will be centre stage in the whole reorganisation, so it is important that the patient voice be heard. How will we do that?

Amendment 220 is about the independence of Healthwatch England in statute and its ability to get the information about health services it will need to do its job. The Government's genuine aspiration to establish an effective system of public involvement requires that Healthwatch England be strengthened by making it truly independent. In fact it deserves it; it has grown into its role and proved its worth. Healthwatch England should provide a national vehicle to drive standards of health and social care and identify areas of poor practice. It has a very special mission that is quite different from that of the regulator, the CQC, of which the Government want Healthwatch England to be a committee. Healthwatch England should be the voice of the people, the voice to which the Secretary of State listens, working in close collaboration with the CQC but also able to hold it to account.

Healthwatch England should be the voice of the abused patient—of the forgotten person with dementia on the second floor of a nursing home, of the child with a learning disability who is getting poor care on a children's ward, of the people waiting for excessive periods for emergency care in an A&E department. When a local Healthwatch or member of the public raises their voice because of a persistent local problem, as occurred in Mid Staffordshire, Healthwatch England must hear it and respond immediately. To do so, it needs to be independent.

Embedding Healthwatch England in the CQC is a fundamental error, as the noble Lord, Lord Hunt of Kings Heath, said. Calling it "a committee" is a fundamental error: it diminishes its power and influence. The only people who think a committee is important are the people who sit on it. Having sat on so many of them, I might agree. It has been argued that locating Healthwatch England within the CQC puts it at the centre of regulation, where it can have real power and influence. However, it cannot have power and influence if it is a committee of the regulator. To have power and influence it needs independence and the ability to challenge the regulator, and to have influence with every local authority in England. It must be seen to be independent, not just called independent. Being independent and being seen to be so requires Healthwatch England to be run by a board that has public trust and confidence, meets in public and speaks to the public, not the board of the CQC.

With the development of the ICS, it is even more important that Healthwatch England is an independent voice of patients and the public. I agree with the noble Lord, Lord Hunt of Kings Heath.

Baroness Tyler of Enfield (LD): My Lords, I support this group of amendments in the name of the noble Lord, Lord Hunt. My name is attached to Amendment 149, but I want to talk more generally about this group. Like the noble Lord, Lord Hunt, I am very supportive of the work of Healthwatch, at both national and local level. It provides very helpful and important insights about what it is like to be at the receiving end of our healthcare system. We sometimes do not hear quite enough about that. The national-local structure is helpful, ensuring that local bottom-up insights are then reflected in national-level reports.

Like the noble Lord, Lord Hunt, I have found some of the reports produced by Healthwatch recently, and during the pandemic, extremely helpful. I am thinking of its work on mental health—particularly, children's mental health. It has also done a series of projects on social care that are very relevant to the current situation. One project particularly dear to my heart involved engaging with care home residents and their loved ones, and feeding insights into the development of national visiting guidance—very practical, important work. Another recent report, which I have already quoted in your Lordships' House, looked at vaccine confidence and, particularly, what might need to be done to help support those communities with a higher degree of vaccine hesitancy; again, Healthwatch does some really important work.

I turn now to the amendments more specifically. In the recent survey of ICS leaders for Healthwatch England and NHS England, 80% of respondents said that they would support Healthwatch having a formal seat on the ICB if this was set out in legislation or guidance. We have already heard the question: what about the other 20%? Should noble Lords have the time, I recommend a quick look at the Healthwatch document and the survey, mapping the relationship between local Healthwatch and integrated care systems. There is a lot of important information in it. I particularly noted in the survey that 100% of ICS respondents said that they would support a mandated seat for Healthwatch on the integrated care partnership. That was one of the main reasons that I wanted to add my name to Amendment 149.

Fundamentally, why I think this so important is that I am not convinced that, in all our important deliberations so far, sufficient weight has been given to what we might call the service user voice or the individual patient voice more generally. These deliberations have, understandably, been very much about structures and how these new integrated care systems will work. I feel that there is scope for the Bill to set out some minimum requirements to ensure that the patient voice is heard at the decision-making table. It is fine to have lots of other sentiments about patient voices but, are they there, and are they heard at that table?

The principle is really quite simple. Patient choice at an individual level—that is, in relation to the patient's own healthcare—has changed radically. We have moved from a situation where the doctor knows best and will tell you what is happening to the doctor setting out the options and you making a decision with the doctor—almost a co-produced decision. We need to think more about that approach, at the community level, the local

[Baroness Tyler of Enfield]
level and then the integrated care system level. This will be particularly important in relation to tackling health inequalities because, frankly, if people are not involved in the decision-making or feel that their voice is not being heard, they often do not trust the outcome.

A recurrent theme in our discussions so far has been who should be on what body. We have had those big debates about whether there should be public health and mental health representatives and so on, which are very important, and those conversations still have some way to go, and we have just had this very interesting debate about place-based partnerships and "insiders" and "outsiders". Again, that has quite a long way to go, but it would be ridiculous if the patient was seen as the outsider; patients need to be front and centre of all this and the reason we are undertaking a restructuring in the first place.

My main plea is that in all our discussions we consider the user voice and how it can be heard. I think that Healthwatch is an obvious way of doing it; it has the existing infrastructure. There may well be other ways of doing it, but that was the reason I was keen to support the noble Lord, Lord Hunt.

Lord Harris of Haringey (Lab): My Lords, I refer to my health interests as declared in the register; in particular, I chair the General Dental Council, but I should make it clear that I am not speaking on its behalf in Committee.

Almost exactly 35 years ago, I became director of the Association of Community Health Councils for England and Wales, which was then the national statutory body representing the interests of the patients and the public in the NHS. Since then, both local and national representation of patients has gone through a series of iterations—indeed, the number of occasions on which I have been sitting on the opposite side of the Chamber from the noble Earl, Lord Howe, talking about patient representation seems too many to recount. After community health councils, we went through a series of iterations of which local Healthwatch is the latest version. I admit that when we had the debate which my noble friend Lord Hunt began by referring to, I was extremely dubious about whether local Healthwatch would be able to flourish and the national body be effective. I have to say that my worst fears have not been founded, but it has to be recognised that the way in which it was structured, in particular the late changes introduced by the Government during that legislation, made it much more difficult for Healthwatch, both at local and at national level, to be as effective as it might be.

The context of this debate is the centrality of patients and service users in delivery. Every time the NHS is reorganised, whether it was the reorganisation of the noble Lord, Lord Lansley, or the reorganisations we have every three years or so, there is always a grand White Paper which says, "Patients will be at the centre of this new structure", but it is never quite like that. In the new arrangements being brought forward, the Government need to make sure that the local patient voice is represented and articulated and that, at national level, those voices can be aggregated and put forward. That is why this group of amendments is so important.

We have just had a debate which ended up revolving around how many separate interests should be represented on the various bodies that we are creating. I can see the problems if we add and add, and how difficult that is going to be. However, what I hope the Government will take away from the consideration of this amendment and look at before Report is how they can make the patient representative structure within the future arrangements better and more effective. I think that a number of things could be done.

The first is about the budgets. The budgets for local Healthwatch go through a complicated, notional process. It is very difficult to define why the allocations are what they are. It would be far better if it was clear what the expectations were to run a local Healthwatch and to deliver what is needed.

The second thing that can be done concerns the degrees of independence: from the local authority, health providers and health commissioners, at the local level, and from the CQC at the national level. The noble Lord, Lord Patel, talked about the problems of Healthwatch England being a sub-committee of the CQC. I understand that the relationship has actually worked quite well, but that is probably because of the good will of all concerned. It might be that, in the future, Healthwatch England has serious criticisms of the regulator. How can it do that, as a sub-committee of that body? Whether formally or informally, you can see the difficulties.

6.30 pm

Similarly, because of the way in which local Healthwatch organisations are created and their relationship, ultimately, to local authority funding, you can see again how, when we are talking about increasing the integration of health and social care, the independence at local level may be compromised. So the question of getting this budget and the constitution right is very important to ensure that you have that independent voice.

I hope that the Minister will take away from this afternoon's discussion the need to look at how they can ensure the future of the patient voice, ensure that it is done effectively and ensure that it is independent and properly resourced. Only by having that independent voice will you improve the quality of healthcare and health services.

I remember that, back in the dim distant days when I was director of the association, and even when I was a community health council member 10 years earlier than that, 45 years ago, it was often the local community health council representative sitting there at meetings with the professionals and managers, all of whom speak their own language, which is rather different from that of the patients. They were being told things about the way in which the local service was operating and being delivered at the local level, which they would not have heard otherwise. That is why, at the centre of our deliberations, at both local and national level, the patient voice must be heard and properly supported and resourced.

Lord Mackay of Clashfern (Con): My Lords, I strongly support that. It seems to me that the National Health Service is devoted to looking after patients.

Therefore, it is very strange that there is no national voice for patients to speak to it. In a way, Healthwatch England fulfils that—but in a very awkward position.

I do not know exactly the relationship within the constitution of the committee and the CQC. For example, it may be important that knowledge that Healthwatch has goes to the CQC, but it must be much better for it to be independent at every level, national and local, and to not take part in any of the particular arrangements but rather independently give the pure voice of the patients, which it has received, as it were, from the people who have been served by the National Health Service, whether that is complimentary or otherwise, according to what has actually happened. That seems to me to be essential. I cannot think that it is effective to have a National Health Service with no voice to be heard at the centre from the patients.

Baroness Walmsley (LD): My Lords, I quite often buy things online and, a few days after the product has arrived, I often get an email saying, "How did we do? Give us one, two, three, four or five stars." That can be very irritating, and I suspect that, on the whole, people do not respond, unless the service has either been dreadful or brilliant—that is certainly so in my case. The voice of the patient is far more important than that and, if we are to assess the performance of different ICSs, the voice of the patient is absolutely fundamental to gathering the evidence, using which we can compare their performance.

A few years ago, I had to be in hospital, just for a few days. At the end of my treatment, when I was about to go home, I was handed a little slip of paper. I do not know if they still do this, but it had some kind of snappy title like, "Tell us how we did". I thought it was totally inadequate, because here was I, as a patient, having had a general anaesthetic, feeling a bit wobbly, but crucially, having had only the experience of that particular treatment in that particular hospital. The beauty of Healthwatch is that it can compare the experience of patients, heard directly from those patients, of a lot of different treatments in different settings. It can bring together the voice of the patient and—absolutely crucially—it has the ear of the people who deliver those services and can authoritatively explain to them where they are doing well and where they are doing badly.

In this group of amendments, the noble Lord, Lord Hunt, and others have got it right in their suggestions about the level at which Healthwatch should have a voice: non-voting membership of the ICB, voting membership of the ICP and, crucially, independence from the CQC. The noble Lord, Lord Harris, put it very well: how on earth could Healthwatch criticise the CQC as the regulator if it is part of it? It is a little bit like asking a civil servant to criticise the Prime Minister, is it not? The noble Lord, Lord Hunt, and others who have spoken have got the level right at which Healthwatch should play its part in this great new world of integrated services. The view of the patient of the experience that they received at the hands of all the health and care services is absolutely crucial to being able to compare the performance of these bodies that we are setting up.

Baroness Wheeler (Lab): My Lords, I strongly support my noble friend Lord Hunt and other noble Lords in their quest in this suite of amendments to underline the important and crucial role played by Healthwatch, particularly at local level, and to ensure that the new NHS structures and processes in the Bill fully recognise this.

Under the 2012 Bill, the noble Lord and others who have put their names to the amendment and who have spoken in today's debate were all strong advocates of Healthwatch, and clearly remain so today. The concerns deeply expressed then of the Government's decision to make national Healthwatch a sub-committee of the CQC, and not the independent organisation that it needed to be, have again come to the fore. Amendment 220 would add a new clause after Clause 80, seeking to establish Healthwatch England as a body corporate that provides an annual report of its activities to Parliament; it has the full support of these Benches. As the noble Lord, Lord Patel, has strongly emphasised, failing to provide for the independence of Healthwatch was a fundamental error that needs to be put right. He set out a particularly strong case, as have other noble Lords this time around.

Amendment 42 to Schedule 2 seeks to ensure that Healthwatch is a non-voting member of the ICB, so that there can be a genuine championing of patients' voices and views, which many noble Lords have spoken so strongly about today. These are views fed back from evidence and surveys conducted by both national and local Healthwatch organisations. At the very least, it is crucial to seek to ensure—as set out in Amendment 103 to Clause 20—that the ICB is obliged to fully consider Healthwatch reports and that that body leads any local consultations proposed in the ICB forward plans.

Amendment 149 to Clause 21, seeking to ensure that ICPs have a Healthwatch nominee in membership, is also important, given the local Healthwatch links to both the NHS and local authority bodies, patients and clients.

Key questions on how Healthwatch, both at national and system level, is to be funded were raised by my noble friends Lord Hunt and Lord Harris, particularly about the whole process of allocating funds. This is important in view of the increased role of Healthwatch in the additional 42 ICSs. I look forward to the Minister's response.

Finally, I also endorse noble Lords' comments on the excellence of the reports produced by national and local Healthwatch organisations. Their guidance on access to social care, mentioned by several noble Lords, and comments on the detailed proposals later in the Bill on the care cap and the recent White Paper, are clear and accessible to service users, and closely examine the impact for them, and for the thousands of people currently waiting for assessment and access to key services. However, those are issues for another day. I hope that the Minister has listened to the debate.

Earl Howe (Con): My Lords, these amendments deal, in their several ways, with the role of Healthwatch both locally and nationally. I begin with Amendment 42, in the names of the noble Lords, Lord Hunt of Kings Heath and Lord Patel, and the noble Baroness, Lady Thornton. This amendment would require ICBs to make provision in their constitutions for a non-voting member to be appointed from local Healthwatch branches.

[Earl Howe]

I lay great importance, as do other noble Lords, on Healthwatch's work on patient advocacy. However, as I said in relation to other amendments on the membership of ICBs—I know this is turning into something of a mantra—we want to avoid the Bill's provisions being too prescriptive. It is essential that we provide local leaders the flexibility to design the board in a way that best suits each area's unique needs. Even a non-voting member risks making the boards less nimble, undermining their ability to make important decisions efficiently. As I am sure the Committee is already aware, the ICB can appoint more members, including a Healthwatch representative, if it wishes, and I am sure many of them will. What is key is that local boards should be able to decide for themselves to appoint individuals with the necessary expertise to address local needs, and we want to allow them as much scope as possible to do so by not prescribing who all those members should be.

That said, I recognise that the growing complexity of health and care demands that we listen to the voice of patients, carers and the public. We want to ensure that they are heard throughout the system. I contend that there is adequate provision in the Bill to ensure that patients and the public are appropriately consulted and involved in decisions made by the ICB. I draw noble Lords' attention to new Section 14Z36, regarding the duty to promote the involvement of each patient, and new Section 14Z44, regarding public involvement and consultation by ICBs.

I listened carefully to the noble Lord, Lord Harris of Haringey, as I always do, about the particular need for adequate and appropriate funding of local Healthwatch. If I may, I shall take away the points he made on that issue and others and write to him about them. We would expect Healthwatch to be closely involved with ICBs in carrying out their engagement and involvement duties. On what do we base that expectation? Many systems already have some system-level arrangements in place with Healthwatch. Indeed, NHS England has published guidance, which would apply to ICBs, on working with people and communities that encourages working closely with Healthwatch. Therefore, given that ICBs will already be required to engage patients closely in their decision-making process, and that we expect Healthwatch will be closely involved in that, we consider it unnecessary to require in legislation a member drawn from Healthwatch.

Amendment 103 would alter ICBs' duties in relation to public involvement to require them to make adequate arrangements for the receipt and consideration of any relevant Healthwatch reports. As I said, the existing ICBs' duties in relation to patient involvement are already comprehensive, and the amendment could unintentionally limit ICBs' ability to form relationships with Healthwatch and other organisations appropriate for their area. As was the case for CCGs, ICBs will be required to make arrangements to involve patients in the planning of commissioning arrangements in areas that may impact the manner in which services are delivered, or the range of services available. This will ensure that patients receive appropriate representation where decisions are being made that could affect them.

I previously mentioned that NHS England, in its guidance to ICBs, has encouraged close working with Healthwatch. This guidance comes with the acknowledgement that what an appropriate relationship with Healthwatch looks like will vary from system to system. For this reason, we are seeking to establish comprehensive duties and requirements in the legislation while leaving the specifics of local relationships with organisations such as Healthwatch for ICBs to determine for themselves.

6.45 pm

Amendment 118 would alter the consultation requirements placed on ICBs and their partner trusts in the development or revision of their forward plans to explicitly include Healthwatch as a facilitator for consultations with the people in the ICB's area. Again, this amendment would create an unnecessary additional restriction on the ICB's ability to carry out its functions in a way that best suits its area.

The provision in question sets out a requirement for ICBs and their partner trusts to consult the people for whom the ICB has responsibility when it seeks to develop or amend its forward plan. This is already a comprehensive requirement, which, in addition to ICBs' general duties relating to patient involvement in decision-making, will ensure that people will have ample ability to have their say in how their ICBs plan and commission.

As I said, and as we all appreciate, local needs will vary, so different approaches for this engagement will be appropriate in different areas. Again, we want to maximise ICBs' ability to conduct engagement under the legislation in a way that best works for them. We would expect Healthwatch to be closely involved in this process for the reasons I gave earlier. The central point is that we want to empower ICBs to work out the relationships with Healthwatch and local people generally that are appropriate for their areas, rather than creating constrictive requirements from the centre.

Amendment 149 relates to the integrated care partnership, which each integrated care board and its partner local authorities will be required to establish. This partnership is intended to bring together representatives from across the system and is tasked with developing a strategy to address its health, social care and public health needs.

To effectively fulfil the statutory requirement to produce a strategy, each partnership will need to involve a wide range of organisations and representatives from across the system, and we would expect a representative of Healthwatch to be a member of an integrated care partnership. However, once again, it is right that local areas should be able to determine the model and membership that best represent their area. As the footprint of many integrated care partnerships will sit across many Healthwatch areas, it would not be prudent to specify that only one representative should sit on the board, rather than give local areas the flexibility for each partnership to make their own arrangements appropriate to their circumstances—they may want more than one, in other words.

Amendment 220 would establish Healthwatch England as a body corporate and allow Ministers to use secondary legislation to set out its functions, board and funding. It is important to seek the perspectives of health and

social care users. We value the voice of patients and use their views and experiences as a driving force for improvement. Healthwatch England is already well established as the independent champion for people who use health and social care services. It has a duty to understand the needs, experiences and concerns of service users and to speak out on their behalf.

Under existing arrangements, Healthwatch England already has the ability to exercise its four main functions: to provide leadership and support to local Healthwatch organisations; to issue recommendations and warnings to local authorities in England; to escalate concerns about health and social care services to the CQC; and to provide advice to the Secretary of State, NHS England and Monitor, and English local authorities. Healthwatch also has a duty to report annually to Parliament on how it has exercised its functions.

I listened with care, as I always do, to the noble Lord, Lord Patel. We believe that Healthwatch England is appropriately set up to carry out this important role effectively. As a statutory committee of the CQC, it has a separate chair and a committee of members who oversee strategy, provide scrutiny and oversight, and approve policies and procedures. The department provides funds annually to support Healthwatch England and local Healthwatch. In 2019-20 alone, over 350,000 people shared their views about health and social care services with Healthwatch England, and local Healthwatch helped over 960,000 people access advice and information. The Healthwatch network used this to make over 5,870 recommendations to improve services, based on people's experiences of care.

I confess I was surprised to hear the noble Lord, Lord Patel, argue that Healthwatch England lacked public trust. I do not agree with him that it is not seen as being sufficiently independent. We have already heard from noble Lords about how well received the reports published by Healthwatch England have been and how authoritative they are seen to be. Healthwatch England is a genuine, and now proven, national voice for patients and I would suggest that it is valuable for the CQC, which has to opine on the outcomes experienced by patients, to have the voice of patients in its midst.

The Bill requires integrated care boards to make arrangements to involve patients in the planning of commissioning arrangements and we expect Healthwatch to be involved in this process. Further, Healthwatch will have a key role to play in integrated care partnerships. It is our expectation that a representative of Healthwatch would be a member of integrated care partnerships. In addition, new Section 116ZB, inserted by the Bill, requires ICPs to involve local Healthwatch organisations in the development of their strategies.

I hope I have given the noble Lord, Lord Hunt, and other noble Lords some reassurance that Healthwatch England is already established, is performing effectively under the CQC and has the ability to perform its duties, purpose and functions. It has had a positive impact on health and care services by ensuring that NHS leaders and other decision-makers hear the user's voice and use feedback to improve care—that is what it is all about. This has been a good and wide-ranging debate. I hope I have reassured your Lordships about the value we place on Healthwatch. However, we must balance this with the values of flexibility and local determination. For those reasons, I ask the noble Lord to withdraw the amendment.

Lord Hunt of Kings Heath (Lab): I am grateful to the noble Earl, Lord Howe, and all noble Lords who have taken part and been supportive of this group of amendments. I very much take what the noble Earl said about the general recognition of the importance of the work of Healthwatch, both nationally and locally, and the way it has gone about doing it. With Sir Robert Francis as the current chair of Healthwatch England, we have someone who commands a great deal of respect and gives the leadership one would expect from a person of that calibre and experience.

What we are looking for, though, is a visible sign of the Government's intent on the importance of Healthwatch, both nationally and locally. Frankly, as the noble and learned Lord, Lord Mackay, suggested in his very helpful intervention, having the status of being a committee of a regulator does not give the right appearance of the importance and independence of this body. My noble friend Lord Harris is absolutely right that there could be circumstances in which Healthwatch criticised the work of the CQC. Indeed, the more the CQC takes on system responsibilities, the more likely that is.

In relation to ICPs, the Government "expect". It is a very short journey between the Government expecting something and putting it in legislation—I hope they will give that some thought.

On the noble Earl's concern about the size of ICBs, given what he said about conflict of interest issues earlier today, he must recognise that the seats will be empty most of the time, as NHS trusts and local authorities will clearly have to excuse themselves from most of the current debates within ICBs, because the boards will be talking about resources, commissioning, the development of services and the forward plan, all of which those organisations will have a direct interest in. That is why the whole structure of ICBs needs looking at again.

I am very grateful to the noble Earl for taking back the issue my noble friend raised about resources and the way the money flows down to Healthwatch. There is a suspicion here; I think the money goes nationally to local government and then you depend on local authorities to decide how much they will give to each local Healthwatch. I am afraid we know, as we have seen in other services, that some of that resource tends to get—how shall I put it?—diverted into other areas. I never understood why the Government thought that this was a good way to fund Healthwatch. If you set it up nationally as an independent body, the obvious thing to do is give the resource straight to national Healthwatch to allocate locally. I suggest the Government give that serious consideration.

This is one issue that we will want to bring back on Report, as it is important that Parliament gives a very visible indication to the NHS that we think Healthwatch is doing a great job but we want to see it have more influence in future. Having said that, I beg leave to withdraw my amendment.

Amendment 42 withdrawn.

Amendments 43 and 44 not moved.

Schedule 2 agreed.

Clause 15: People for whom integrated care boards have responsibility

Amendment 45 not moved.

Clause 15 agreed.

Clause 16: Commissioning hospital and other health services

Amendment 46

Moved by ***Baroness Bennett of Manor Castle***

46: Clause 16, page 13, line 28, leave out "it" and insert "the Secretary of State"

Member's explanatory statement

This amendment, with the new Clauses before Clause 35 in the name of Baroness Bennett of Manor Castle, 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.

Baroness Bennett of Manor Castle (GP): My Lords, in moving Amendment 46, I will speak also to Amendments 168 and 169 in my name. In an earlier group this morning we were talking about democratic accountability at the local or ICB level, particularly in relation to Amendment 23 from the noble Baroness, Lady Thornton. We were also, through the agency of Amendment 45 from the noble Lord, Lord Davies of Brixton, looking at the risk that people in England could be left without NHS cover. Those amendments were about the ways in which this Bill could go horribly wrong—certainly, I have no doubt, in terms of what the public want, if not necessarily in the unintended consequences of where the Health Secretary and the Chancellor are apparently thinking of taking our NHS.

A couple of hours ago, the noble Lord, Lord Hunt of Kings Heath, talked about how the Government are centralising power, with ICBs having to look upwards to the hierarchies above them. He used the phrase that they will be "beaten up by the centre". As he was saying that, I was struck that a briefing arrived in my inbox at that moment from the NHS Confederation, NHS Providers and the King's Fund, which very much focused on that concern about the Secretary of State's power to direct. It is clear that the Bill will give the Secretary of State enormous power potentially to interfere in the most minute aspects of healthcare locally. That concerns a great many people. I think it is already clear that your Lordships' House will keep talking about this and, very likely, try to change it in future, but we know we are unlikely to be able to entirely transform this Bill and the relationships between the centre and the local.

7 pm

I come to a phrase: with power comes responsibility, and with great power comes great responsibility. I went looking for the origins of that phrase and it can be attributed back at least to the French revolutionary national convention or possibly to the King James Bible. The fact that it is to be found in many political contexts across the political spectrum perhaps shows that it might be considered uncontroversial.

I ask the Minister: where is the attribution of central responsibility in this Bill? That is a serious question. Where does the Minister think the responsibility of the Secretary of State to ensure that healthcare is available to every person in England resides in the Bill, or does he want to say that such a responsibility does not exist? If Americanisation steams ahead—and let us not forget the US has astonishingly high healthcare costs, with results resembling those of countries with vastly less funds—who will be held to account for that? That is what this group of amendments seek to achieve; to ensure that the Secretary of State is responsible for the outcomes of the Government's Bill.

This group of amendments aims to restore the NHS in England as a public system as it continues to be in the rest of the UK and as it used to be in England. I do not want to get too far into the weeds and noble Lords can read the amendments and explanations for themselves, but I am aware that the meaning of the amendments is not particularly obvious in the text, particularly the first, so I will briefly run through them.

Amendment 46 replaces the word "it", which refers to integrated care boards and their duties, so the amendment makes it the duty of the Secretary of State to commission health services

"to meet the reasonable requirements of the people for whom it has responsibility".

That means the Health Secretary having responsibility for the people in England.

Amendment 168 restores the wording of Section 1 of the NHS Act 2006, giving the Secretary of State the duty to promote the comprehensive health service. It very closely echoes the wording in the founding National Health Service Act 1946.

Amendment 169 says that the Secretary of State must provide, to a level

"necessary to meet all reasonable requirements",

services including hospital, medical, dental, ophthalmic, nursing and ambulance. I note particularly proposed new subsection (d), which refers to

"the care of pregnant women … and young children"

and picks up some of the issues we were referring to in the first group today. On reflection, we could perhaps improve the wording of that, but it is a start in terms of acknowledging the needs of children in the Bill.

The wording in both these amendments very closely reflects what was found in the 1946 Act, and in every Act up until 2012. I think it is worth reflecting a little on why that wording disappeared from the 2012 Act. It was because there was a move towards market-based structures and so we were relying on the market to provide. That has in this case, as in so many others, proved to be a disaster. Indeed, in bringing forward this Bill in this moment the Government are acknowledging that disaster.

The timing of this Bill is very interesting. As both Opposition Front-Benchers have noted, it comes at a time when the NHS is struggling to cope, yet it is facing this massive reorganisation. In terms of Amendments 168 and 169 I find myself in a situation I am not in very often; I am advocating to the Committee that we revert to

the old, the tried and the tested—the kind of NHS that there is bountiful evidence the public actually want.

Similar amendments to these were moved in the other place. I note that in the discussion there it emerged that in the 2012 Act there was a compromise amendment. This arose, at least in part, out of the Constitution Committee. The compromise wording was:

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

I cannot see similar wording in this Bill, but it is long and complex, so I would be interested if the Minister could point me to anything that he sees as similar to that 2012 compromise.

In the debate in the other place, the Minister said that this change was

"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".

Those words, "in practice", are rather telling. We find ourselves, as we so often do, hearing from the Government, "Don't worry; things will work out. You can trust us. This does not need to be on the face of the Bill". That is something your Lordships' House very often—I would say rightly—expresses great scepticism about. We want to see things in law to which the Government can be held to account.

We know all too well how creaky parliamentary accountability can be: how stretched and limited scrutiny in your Lordships' House can be, let alone in the other place, where 44% of the vote in 2019 delivered 100% of the power to the Government. There is brilliant work done by Select Committees and brilliant questions asked by individual MPs to highlight issues, but the practical reality is that the Government can just ignore all those things and bulldoze through, and very frequently do.

I note that in the other place, the Minister further said that

"we should be wary about being overly prescriptive in primary legislation."—[*Official Report*, Commons, Health and Care Bill Committee, 14/9/21; col. 183.]

But surely being prescriptive about the fact that we have a National Health Service is what the public unarguably want. The Government are being prescriptive about how they can control ICBs to control local services, but I would say that we have to be prescriptive about what the Government must do. That is a responsibility we must live up to. This is surely not overly prescriptive. I beg to move.

The Deputy Chairman of Committees (Baroness Henig) (Lab): My Lords, the noble Baroness, Lady Brinton, is taking part remotely, and I invite her to speak.

Baroness Brinton (LD) [V]: My Lords, I am speaking in support of the amendments in the name of the noble Baroness, Lady Bennett, starting with Amendment 46. After many helpful discussions both today and earlier on in Committee looking at membership, structures and representations of ICBs, these amendments take us back to the first principles and ask your Lordships' House to look at what should be in scope for the provision of NHS services. This is a really valid question.

The noble Baroness, Lady Bennett, referred to maternity services, but if I were to pick one of the services listed in Amendment 169, it would be dental services. There are millions of people in the country who cannot access an NHS dentist. The result is a worsening of dental health, which is especially worrying for children and young people. I am sorry to say that, over the years, Ministers have ignored the wider needs of the public regarding dental services. I think the point about specifying the provision of services such as this puts a very particular duty on the Secretary of State to force Ministers to make sure that they are also holding other parts of the health service to account.

The amendments turn our focus on to whether we still have an NHS that is a public health system or one that perhaps is paid for mainly by the public but run by a disparate number of bodies, including unaccountable private companies increasingly not based in the UK. They are particularly important in light of the report today in the press that the Secretary of State is planning to create the equivalent of school academies for failing hospitals and says that there will be a White Paper in due course. Just as an aside, do we need yet more reforms? Surely it would have been better to have a full range of Green Papers with an overarching vision of what the NHS in the 21st century should look like and how the structures should work. We are now waiting for two White Papers, while the passage of this Bill is irrevocably changing the structures of our NHS system.

Today's announcement rings a number of alarm bells because there is an analogy with the education sector that is quite helpful. I remember that, in the 1990s, academies were going to be free from local authority control and that that, on its own, would inevitably make them improve—but that has not been the case. Various reports over the last 20 years have shown that a number of failing schools taken into multi-academy trusts and free schools have remained low performing. Structures on their own do not necessarily resolve this. Indeed, some multi-academy trusts have failed in their entirety, and one of their issues is the lack of public accountability—because Ministers have direct responsibility in the public realm for academies, and I worry that the Secretary of State may be proposing the same. If I was a senior leader in NHS England, I would be very concerned about that.

I am grateful for the earlier comments of the noble Earl, Lord Howe, on the need for Ministers to have the ability to appoint and, presumably, remove senior personnel on ICBs. But would the Secretary of State have responsibility for these academy equivalents and give them the right to access separate funding for capital expenditure and special projects? I raise this because part of the problem that we have at the moment is a diversity of funding mechanisms, structures and strands, which often take the eye of a leader—whether a Minister or one in the NHS—away from the provision of services.

The foundation of a public system was essentially removed by the 2012 Act, and, as the noble Baroness, Lady Bennett, said, the Constitution Committee suggested that there needed to be an interim remedy. It is important that we have reassurance that this Bill will not weaken it any further at all. I hope that the Minister can

[Baroness Brinton]
reassure your Lordships' House that the Government want to protect the provision of NHS services, as part of a truly public health service.

Baroness Wheeler (Lab): My Lords, I thank the noble Baroness, Lady Bennett, for moving her amendment and other noble Lords for their contributions, particularly on the specific points about particular services, such as dentistry. All three amendments look back to the Health and Social Care Act 2012 and the National Health Service Act 2006 on the powers and duties of the Secretary of State in relation to the NHS and the services that it provides, restoring certain provisions in the 2006 Act.

Under the Bill, the ICBs and NHS England will have the duties to secure the provision of the services that make up the comprehensive NHS. There are probably noble Lords here today who were Members of your Lordships' House in 2006. I came in in 2010, just as the equally marathon Health and Social Care Act from the coalition Government got under way, when the whole issue of the Secretary of State's powers and duties came to the fore. As explained at the time, the aim was to separate the political from the operational responsibility and to better align the language to the reality of the purpose of the NHS, in "securing the provision of services".

The arguments in 2010 and 2011 were fierce and passionate, centred around the subtle changes in the way that the duties were defined, as compared to the words in Sections 1 and 3 of the 2006 Act. They caused suspicion, confusion and fears that the NHS would be changed forever. These arguments remain a bit of a blur in my memory, but I recall the overwhelming view among leading experts on NHS law that the changes were technical and did not involve any substantial change in practice. We know that, in respect of this role, no change has happened.

I also recall the 2012 consideration of the issue by our Constitution Committee and the compromise recommendation subsequently adopted in the 2012 Bill of what became Section 1(3) of the 2006 Act, as amended:

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

No matter what is in any Act, this is and will always be the political reality.

Currently, the law places the duty on the Secretary of State to

"continue the promotion in England of a comprehensive health service designed to secure improvement … in the physical and mental health of the people of England, and … in the prevention, diagnosis and treatment of physical and mental illness"—

very much in the spirit of the NHS's founding 1946 Act.

Amendments 46 and 168 seek to continue the 2006/2012 debate. It was claimed about the 2012 Act, and now about this Bill, that the change in wording implies that people will be denied access to treatment from the NHS because, for example, a particular ICB decides to exclude a service and because there is no duty on the Secretary of State to prevent this happening. However, there is no evidence that anyone has ever been denied access to an NHS service or that any service has been refused in general simply because of the change in the wording of the responsibilities of the Secretary of State. Amendment 169 returns to the same point, seeking to place a duty on the Secretary of State to "provide" a list of services, with some general headings such as ambulance services. But the reality is that this is not how the NHS functions or indeed ever has.

I endorse many of the comments made by the noble Baroness, Lady Brinton, about today's announcement of yet another restructuring on the academy front, but, again, that is a debate for another day.

We could go back on the Secretary of State issue to the 2012 arguments and spend a lot of time on it. While we fully understand the concerns and fears that the current wording could engender among those who suspect a deeper reason for the changes in language, continuing to argue over this issue would not be very productive or get us anywhere. We need to get on with scrutinising the sweeping delegated and Henry VIII powers later in the Bill that our current Constitution Committee and Delegated Powers Committees have expressed such deep concern about.

7.15 pm

Earl Howe (Con): My Lords, I too am grateful to the noble Baroness, Lady Bennett of Manor Castle, for bringing forward this group of amendments. As many of the Committee will remember vividly, and as the noble Baroness, Lady Wheeler, has reminded us, accountability for the health service was a topic of considerable debate at the time of the Health and Social Care Act 2012 as it went through Parliament. The constitutional position of the Secretary of State was closely scrutinised and the current wording in the Act is very much the product of those discussions. I remind the Committee especially of the hard work done by the noble Baroness, Lady Jay of Paddington, who was at that time chair of the Constitution Committee, her colleagues on the committee and many others, including my noble and learned friend Lord Mackay of Clashfern, who did so much to develop the current wording of the clause. The coalition Government accepted the Constitution Committee's recommendations in full.

I am afraid that I do not agree with the noble Baroness's characterisation of the reasons why it was thought appropriate to modify the wording that described the Secretary of State's responsibility for the health service. As noble Lords will be aware, the idea that the Secretary of State himself provides services has not for many years reflected the real world. As the noble Baroness, Lady Wheeler, rightly said, and as the Committee will remember, it was decided in 2012 that it was better that the law reflected the reality of the modern NHS rather than retaining outdated language. I do not think that the last 10 years have proved that proposition wrong. The current legislative framework allows some of the health services in England to be provided by entities, such as NHS foundation trusts, that are legally distinct from the Secretary of State. That will continue to be the case and should be recognised in the law.

I understand the concerns that Ministers might somehow avoid being responsible for ensuring the continuation of a comprehensive health service. However, there have been many vigorous debates in Parliament

about the NHS in the years since those changes in 2012, and they have demonstrated that there has, quite rightly, been no loss in the strong sense of governmental accountability for the NHS felt by both government and Parliament. Indeed, the House amended the Act in 2012 to put beyond doubt that:

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

That has not changed in this Bill; the wording will remain set in statute.

I would gently caution against recreating the fiction that the Secretary of State provides services directly. It is much better to be clear that the role of the Secretary of State is to set strategic direction, oversee and hold to account NHS England and the other national bodies of the NHS and, occasionally, to intervene—as the noble Lord is doing.

Lord Hunt of Kings Heath (Lab): I thank the noble Earl for giving way. Given what he has said—and I know that we will debate this later—I point out that it is curious that the Government wish to take on a power of direction over NHS England, if that is so. I guarantee that that power will never be used because the Secretary of State's power of direction never has to be used. Once this is passed, that changes the relationship; NHS England will know that the Secretary of State has that power of direction. Although I have tabled some amendments to try to modify it, I have no objections to the general principle, since I do not think that a quango such as NHS England should be freely floating. But we need to recognise that it is a fundamental change in the relationship to impose that power of direction again.

Earl Howe (Con): My Lords, as I was about to say, the 2012 Act does provide for the ability of the Secretary of State to intervene when that is necessary for the smooth and effective running of the system. Furthermore, we should not exaggerate the extent to which this Bill modifies the 2012 provisions. As the noble Lord said, we will debate the powers of direction on a future occasion but, when we come to do so, my colleagues and I on the Government Benches will contend that the powers of direction, such as they are, are very narrow and specific in their scope. They have been deliberately framed in that way to reflect experience over recent years. I would not be in favour of reopening this piece of drafting, given its history and the effort that noble Lords from all sides of the House made to build an effective consensus in respect of the 2012 Act.

The noble Baroness, Lady Brinton, asked about dental access. The department is working closely with NHS England to increase levels of service as quickly as possible. Practices are continuing to prioritise patients based on clinical need. Dental practices are now being asked by NHS England and NHS Improvement to deliver at least 85% of contracted units of dental activity—UDAs—between January and March 2022 to provide improved access for patients. These updated figures are based on what many practices have been able to deliver to date. They take into account adherence to the latest infection prevention and control guidance. I hope that this is helpful to the noble Baroness.

I hope also that I have explained to the noble Baroness, Lady Bennett, why I cannot entertain her amendments, but also that I have reassured her that the accountability chain between health services, Ministers and Parliament, which lies at the centre of her concerns, remains intact.

Baroness Bennett of Manor Castle (GP): My Lords, I thank the Minister for his response and thank all noble Lords who have taken part in this debate. I particularly thank the noble Baroness, Lady Brinton, for her support. She stressed how this is very much about restoring a public health system with full public accountability.

I was a little surprised, not so much by the direction as by the emphatic nature of the comments from the noble Baroness, Lady Wheeler, given that it was members of her party who moved the amendments in the other place. To address the Minister's comments—this also picks up the point raised by the noble Lord, Lord Hunt—we are talking about a significant change in relation to power of direction; a power that we will be discussing further, at great length, and about which we have seen considerable expressions of concern. I come back to the way I framed my speech: if you have more powers, you have more responsibility. If you say, "We covered all this in the 2012 Act—it's all fine", once could argue that the 2012 Act did not work out fine, but we are in a new situation, creating very new structures.

Thinking about the success or otherwise of accountability, some issues where we have failed in terms of accountability—and we will see amendments on these later—are workforce planning and, as the noble Baroness, Lady Brinton, highlighted, dental provision.

This is about ensuring that people have faith, know who to look to and cannot be fobbed off, as the noble Baroness, Lady Brinton, said, by this terrible, complex diversity of funding and arrangement structures. Like other Members of your Lordships' House, I took part in the public debate in 2012, not in this place but in the public domain, and I have given many speeches on this issue. The complexity must not be allowed to cover over the fact that what people want to know is that the healthcare is there when they need it, and if it is not that they know who to point to.

I will of course withdraw the amendment at this point, but I reserve the right to consider this and come back to it at a future point.

Amendment 46 withdrawn.

House resumed.

Baroness Chisholm of Owlpen (Con): My Lords, I suggest that we adjourn the House for four minutes, until 7.30 pm.

7.26 pm

Sitting suspended.

Ukraine

Statement

The following Statement was made in the House of Commons on Monday 17 January.

"With permission, Mr Speaker, I will update the House on the situation in Ukraine.

As of today, tens of thousands of Russian troops are positioned close to the Ukrainian border. Their deployment is not routine; they are equipped with tanks, armoured fighting vehicles, rocket artillery and short-range ballistic missiles. We and our allies have legitimate and real cause for concern that the configuration and scale of the force being assembled, supported by Russian air and maritime long-range strike capabilities stationed in the region, could be used for the purpose of conducting a multi-axis invasion of Ukraine, but whatever final decision the Russian Government take on the use of such forces, their presence and levels of readiness are contributing to a destabilising and coercive atmosphere that risks miscalculation at best, and at worst, conflict.

Furthermore, in recent weeks, we have observed hardening Russian rhetoric, heightened cyber activity and widespread disinformation that could serve to provide a false pretext for a Russian military intervention. False narratives are very much part of the Kremlin's playbook; they were used in 2008 before Russia's invasion of Georgia, and in Ukraine in 2014. False narratives are being peddled again today: Russia has suggested that its military build-up on the border of Ukraine is in response to NATO aggression and an agenda by the West to use Ukraine to divide and rule the Russian nation. It has put forward this outlandish notion that NATO is attempting to encircle Russia.

Let me be clear. No one is trying to rule the Russian nation. Only one-16th of Russia shares a border with a NATO ally, and NATO is and always has been a defensive alliance. NATO, at its core, holds a belief that any country in the alliance, no matter how big or small, is by right of membership owed a pledge of mutual defence: if you attack one of us, you attack us all.

From 12 founding countries in 1949, the NATO alliance has grown to a total of 30 today. Those countries have joined the alliance not because NATO is making them do so, but because of the freely expressed will of the Government and people of those countries. Countries choose NATO; NATO does not choose them. If Russia has concerns about the enlargement, it should perhaps ask itself why, when people were free to choose, they chose NATO.

NATO is an alliance of like-minded nations that, as well as sharing a commitment to mutual defence, share a set of common values. The sovereignty of other nations is respected by all. Each nation has a sovereign right to choose its own security arrangements. That is a fundamental principle of European security—one, indeed, to which Russia has subscribed in the past—yet Russia now seeks a veto over who joins NATO.

The United Kingdom will stand up for the right of countries to choose their alliances. More important than the choice they make is the right to have that choice. On my recent visit to Sweden and Finland, two non-NATO countries, it was clear that Kremlin attempts to dictate what sovereign states can or cannot choose had been rejected across the political spectrum.

I must stress that no one wants conflict. The Ukrainians are not seeking confrontation, despite the illegal annexation of their lands in Crimea and the occupation of Donbass, and I am sure that ordinary Russian people who remember the first Chechnya conflict and other, older conflicts do not want yet another quagmire either. Last week, there were intensive discussions on the international front to achieve a diplomatic solution to the current situation, including at NATO and the Organization for Security and Co-operation in Europe. Engagement at the NATO-Russia Council made it clear that NATO is open to dialogue with Russia on a range of issues to protect Euro-Atlantic security, including risk reduction, transparency, arms control and lines of communication, but we will not reward aggression.

We are open to dialogue on a bilateral basis. On 23 December, the Chief of the Defence Staff, Admiral Tony Radakin, spoke with his Russian counterpart, General Gerasimov. In their call, they agreed the vital importance of maintaining communications to understand each other's intentions and to avoid miscalculation.

When the Prime Minister spoke to President Putin on 13 December, he expressed the United Kingdom's deep concern over the build-up of Russian forces on Ukraine's border, and also reiterated the importance of working through diplomatic channels to de-escalate tensions and identify durable solutions. The Foreign Secretary continues to engage with the Russian Foreign Minister, Sergei Lavrov, including recently in person at the margins of the OSCE Ministerial Council in Stockholm on 2 December.

Russia has the largest conventional force of any single nation in Europe. It has a proud history. We have fought together. We celebrated the courage of the Arctic convoys at the 80th anniversary last year. Russia is a nuclear power. It does not have anything to fear from NATO or Ukraine or the other countries that strive peacefully on the continent of Europe. Today, I am extending an invitation to my Russian counterpart, Sergei Shoigu, to visit London in the next few weeks. We are ready to discuss issues related to mutual security concerns and engage constructively in good faith.

The UK's position on Ukraine is also clear. We unequivocally support its sovereignty and territorial integrity within its internationally recognised borders, including Crimea. Ukraine is an independent, sovereign country of proud, independent Ukrainian people. The UK Ministry of Defence already has a long-standing relationship with our Ukrainian counterparts, and we continue to provide support in many areas, including security assistance and defence reform. Since 2015, the UK has helped to build the resilience and capabilities of the Ukrainian armed forces through Operation Orbital, which has trained more than 22,000 Ukrainian troops. We maintain the right to deliver bilateral support to a sovereign nation when requested in areas that will better help them defend themselves.

It is important that Ukraine has the capability to defend itself. After Ukraine lost large parts of its navy to Russia's illegal occupation of Crimea, it became important to help Ukraine build up and sustain a

naval capability. We should not forget the thousands of Ukrainians who have lost their lives defending their country and who, every day, are murdered by snipers from across the divide. That is why, in 2019, I expanded Operation Orbital to include naval co-operation, and that is why, last year, we agreed a range of measures, including supplying Ukraine with two mine countermeasures vessels as well as agreeing the joint production of eight new ships equipped with modern weapons systems—defensive weapon systems.

As I said in the House last week, the framework agreement presented to Parliament in November 2021 affirmed the principles that the UK will provide both training and defensive capabilities to Ukraine to help it best defend itself. Within that same principle, I can today confirm to the House that, in light of the increasingly threatening behaviour from Russia and in addition to our current support, the UK is providing a new security assistance package to increase Ukraine's defensive capabilities. We have taken the decision to supply Ukraine with light, anti-armour defensive weapons systems. A small number of UK personnel will provide early-stage training for a short period of time within the framework of Operation Orbital before returning to the United Kingdom.

This security assistance package complements the training and capabilities that Ukraine already has and those that are also being provided by the UK and other allies in Europe and the United States. Ukraine has every right to defend its borders, and this new package of aid further enhances its ability to do so. Let me be clear: this support is for short-range and clearly defensive weapon capabilities. They are not strategic weapons and pose no threat to Russia. They are to use in self-defence. The UK personnel provided in the early-stage training, as I have said, will return to the United Kingdom after completing it.

The Prime Minister has been clear that any destabilising action by Russia in Ukraine would be a strategic mistake that would have significant consequences. That is why there is a package of international sanctions ready to go that will make sure that Russia and its Government are punished if they cross the line. But the cost of an invasion will not just be felt by the West. I have visited Ukraine five times since 2016, and I know that the Ukrainians are a proud people who will stand and fight for their country, for democracy and for freedom. Any invasion will not be viewed as a 'liberation', but as an occupation and I fear that it could lead to huge loss of life on all sides.

The current difficult relationship with the Kremlin is not the one we wish to have in the United Kingdom. It does not have to be this way. The UK respects the people, culture and history of Russia. We have more in common than we may think—culturally, historically and technologically. We wish to be friends with the Russian people, as we have been for hundreds of years. There is a world in which we can establish a mutually beneficial relationship with Russia, working together on shared areas of interest and addressing mutual security concerns. The current gap is wide but it is not unbridgeable. I still remain hopeful that diplomacy will prevail. It is President Putin's choice whether to choose diplomacy and dialogue or conflict and consequences. But Russia's current behaviour is not only threatening the sovereignty of a proud nation state; it is also destabilising the rules-based international order and challenging the values that underpin it. That is why it is all the more important that we stand in solidarity with those who share our values, including our NATO allies and partners like Sweden, Finland and Ukraine."

7.30 pm

Lord Tunnicliffe (Lab): My Lords, this new and sensible procedure of not reading out the Statement because we have all read it leaves me with the problem of how to open one's speech. I will compromise by thanking the Minister for coming to answer our questions.

I do not really have anything new to say. To emphasise that, I am going to read out the first paragraph of the shadow Secretary of State's reply to the Statement in the other place, because my position will not deviate from it. He said:

> "I welcome its contents and make clear Labour's full backing for the steps the Government have been taking on international diplomatic efforts to de-escalate threats, on defensive support for the Ukraine military, on necessary institutional reforms within the country, and on tough economic and financial sanctions in response to any fresh Russian invasion into Ukraine."—[*Official Report*, Commons, 17/1/22; col. 63.]

So I do not believe that we differ in any significant way from the Government. However, I have some questions.

I understand that 13,000 Ukrainian citizens have been killed in the conflict so far, and many must have been killed on what I will loosely call the Russian side. The first objective must surely therefore be to stop the killing. Moving into the area of objectives, could the Minister set out what our policy is, first, on direct military engagement and, secondly, on recognising any of the Russian concerns? I hope she will reaffirm that we are overwhelmingly committed to a diplomatic solution; those diplomatic solutions do not look very optimistic but I hope she can flesh out some strands of optimism.

In 1994—I may get these things slightly wrong—the Budapest agreement was signed and Britain is the guarantor of that agreement. As I understand it, although I cannot claim to have read it, it was a comprehensive agreement that settled the future of Ukraine. It settled its boundaries and did a brilliant job of denuclearising the country, and we would all have hoped that that was how it would settle down. The agreement sought to answer all the questions. Now I have to ask the Minister whether it has any relevance today at all.

In 2014 the Normandy format was created—in Normandy, I believe, because it had its essence at the Normandy celebrations. It is a format of four countries: France, Germany, the US and Russia. On 6 January this year, it met. As far as one can tell, there was little progress, but, hopefully, we have some way of getting to the essence of what those conversations were. My simple question is: was there any progress?

A second institution is the NATO-Russia Council, which has been meeting somewhat infrequently. However, it met on 12 January. Reports from the Secretary-General of NATO seemed a bit downbeat, but does the Minister have any more positive interpretation of what happened? Are there any areas for optimism?

[Lord Tunnicliffe]

Like any Opposition, even when we agree with the Government, we inevitably end up saying, "You should try harder", and I shall say that they should try harder. Should there be more diplomatic effort? I am not saying that the Government do not grasp this, but the news, for want of a better barometer, does not seem to grasp just how serious the situation is. There have been a number of efforts by UK diplomats and politicians to meet the Ukrainian Government, but should there be more? Should the Foreign Secretary visit Ukraine? Should there be something as innovatory as the Defence Secretary going to Moscow?

My experience of negotiation is somewhat depressing. One of the things that is depressing about negotiation is the success of negotiation by attrition. What I mean is, if you spend enough time talking in concert with your allies and you talk and listen to the other side of a debate, you get closer by sheer volume. Therefore, I encourage the Government to see where more face-to-face contact can take place and where there can be more conversations between different people, or different nuances. I seek an assurance that we are using our best skills to try to understand the Russian position. There must be people in Russia who recognise just how serious and dangerous this is. We have to try to find some common ground and we have to ask ourselves—I know a lot of people are concerned about it—whether we retain sufficient diplomatic capability in the Russian area. Do we have adequate Russia skills?

Our military support was clearly welcomed by Ukraine, but I do not know what it consisted of. Perhaps the noble Baroness could flesh that out. How many UK personnel were involved? How many are still in Ukraine and are they at risk? There is an interesting phrase in the Statement that I hope the noble Baroness can flesh out. It says that we are supplying Ukraine with anti-armour defensive weapons systems. I guess if you are in a tank with a missile coming towards you, it is a bit difficult to interpret why this is only a defensive system. How does one signal to the enemy that what we are providing to Ukraine is a weapon that is really only usable in a defensive situation? How many personnel are involved in the training to use this weapon? Are any left in Ukraine?

Ukraine recently suffered a major cyberattack. It is not mentioned in the Statement, but I understand that a new cyber co-operation agreement has been concluded between NATO and Ukraine. What role will Ukraine play in this? Is it already active?

Finally, on the reference yesterday to the Indo-Pacific tilt, can the Minister confirm that resources must be centred on Europe and NATO? AUKUS is a great concept, but it must not draw resources from where the threat is greatest.

As I said at the beginning, we have no fundamental criticism of the Government. We face a very grave situation. History teaches us that wars are much easier to get into than to get out of. If war breaks out in eastern Ukraine, many people will die. All efforts must centre on securing peace.

Lord Campbell of Pittenweem (LD): My Lords, I take no issue with the terms of the Statement, nor with the remarks of the noble Lord who has just spoken, but I think it is helpful if we try to put into context the political objectives of Mr Putin. Put baldly, they are these: to break Ukraine and to intimidate NATO. Mr Putin sees a client Ukraine as essential to Russia's interests and believes—I believe, falsely—that western capitals will back down in the face of his aggression. The overarching purpose is to create a sphere of Russian interest in eastern Europe—an objective for which, I may say, he was given some encouragement by the sometimes lukewarm support given to NATO by President Trump.

It is clear, in my judgment, that any accession to Mr Putin's demands would break both Ukraine and NATO itself. The truth is that NATO poses no threat to Russia. If we consider the enhanced forward presence with which the United Kingdom is most closely associated, the deployment of the battle group to Estonia, it consists of some 900 men. That will hardly challenge the substance of the Russian state.

We should not forget, though, that the people of Ukraine have been under considerable stress and strain. They have been under cyberattack in a particularly personal way, and we know now that there is the threat of false flag diversions. However, I am clear in my mind that we are right to support the Government of Ukraine politically and to provide them with defensive weapons. I am clear in my mind that we are right to make it clear that the United Kingdom will be part of severe economic measures against Russia if military action is commenced. The people of Ukraine continue to show their courage and resilience in the face of provocation and imminent threat, but, increasingly, they show that they wish a future in the Euro-Atlantic community, which is their sovereign right, and one that we should be willing to defend.

I have but two questions for the Minister. What discussions have the United Kingdom Government had with other members of NATO and the European Union to ensure unity of purpose in both those organisations? In particular, why was it that RAF aircraft, two C17s, taking defensive weapons to Ukraine, chose not to fly over Germany? Was there a political reason behind that decision?

The Minister of State, Ministry of Defence (Baroness Goldie) (Con): My Lords, I first thank the noble Lords, Lord Tunnicliffe and Lord Campbell of Pittenweem, for their very helpful comments and constructive approach. On behalf of the Government, I express my appreciation of that. In different ways, both noble Lords analysed the issue in a manner from which I could not diverge, and I am grateful to them both for that contribution.

I will try to deal with the points that were raised. The noble Lord, Lord Tunnicliffe, is absolutely right that, clearly, there is a shadow hanging over Ukraine. If you look at the history and, as he rightly said, reflect on Ukrainian casualties, you see that this is, quite simply, a situation that no one wants to see proceed to aggressive incursion—hence the concerted effort by different countries in different groupings to try to prevail upon Mr Putin to de-escalate the tension and agree to sit down and discuss things by way of dialogue. On de-escalation, I say to the noble Lord that the recent

initiative by the UK is not engaging in any aggressive action against Russia; it is simply supporting Ukraine as a sovereign nation to defend itself against threat.

The noble Lord asked about the UK objectives. The UK, of course, respects the people, history and culture of Russia, but the current relationship with the Russian Government is certainly not one that we want. As the noble Lord, Lord Campbell, alluded to, Russian state threats, such as cyberattacks, disinformation, proxies and electoral interference, are quite simply evidence of ongoing malign behaviour, and they are unacceptable. The objectives of the UK are twofold: to work with our partners in NATO to try to contribute to a de-escalation of this situation, and to also work on a bilateral front with Ukraine, which is a good friend and a bilateral defence partner, to reassure it that we stand with Ukraine and will do everything we can to support it.

The noble Lord, Lord Tunnicliffe, referred to the Budapest memorandum, which is indeed still relevant. We believe that both the UK and the US should insist that Russia stand by the international agreements it has signed up to. That includes the commitment it made in 1994 to respect Ukraine's sovereignty and territorial integrity. Indeed, the Political, Free Trade and Strategic Partnership Agreement signed with Ukraine on 8 October 2020 reaffirms the UK's commitment to the security assurances enshrined in the Budapest memorandum of 5 December 1994.

The noble Lord, Lord Tunnicliffe, asked about the role of NATO and its objectives. I simply repeat what the dual-track approach of NATO has been: a combined deterrence, defence and dialogue approach, where allies speak with one voice. That was delivered at the meeting of the NATO-Russia Council last week. The message was clear: Russia must de-escalate and respect its international commitments, to which we have all freely agreed. To reassure the noble Lord, NATO stands ready to engage in constructive dialogue with Russia to discuss mutual security concerns and has invited Russia for further sessions with the NATO-Russia Council to discuss arms control, risk reduction and transparency measures.

The noble Lord, Lord Tunnicliffe, exhorted the Government to try harder. I accept that challenge; I do not think anyone pretends to have the monopoly of knowledge or wisdom in this situation. I reassure your Lordships that the Government will strenuously do everything they can to promote dialogue and discussion. Indeed, the Defence Secretary in the other place confirmed that he had invited his opposite number in Russia to come to London for discussions.

I agree completely with the noble Lord, Lord Tunnicliffe, on his reference to dialogue. He is absolutely right: it is essential that, whatever else may be going on, we try to keep channels of communication open. I reassure him that, certainly, that is what we are striving to do within defence. He is absolutely correct that the only way to achieve these objectives of de-escalation and a move to a more constructive, intelligent conversation about Russia and how these issues might be addressed in a peaceful manner is by such dialogue.

The noble Lord, Lord Tunnicliffe, asked about the UK military support to Ukraine. As he will know, since 2015, we have been engaged in Operation Orbital. That is all about helping Ukraine to build resilience within its armed forces, and it includes, importantly, the Ukrainian Naval Capabilities Enhancement Programme, which was signed in June of last year. That was a significant agreement because it affirmed that the UK was open to supplying Ukraine with defensive weapon systems as well as training. That principle remains.

The noble Lord asked specifically whether the weapons that have been delivered are usable only in a defence situation. I wish to reassure him that the answer is yes. They are not for use by either the UK or Ukraine in an aggressive capacity. They are simply there to support Ukraine in self-defence if that need arises. In response to the noble Lord's concern—we had an interesting discussion yesterday about AUKUS, which was positive and well-informed—I say to him that NATO is regarded as a cornerstone of the UK MoD's approach to defence and to our capability.

The noble Lord, Lord Campbell of Pittenweem, gave a very accurate analysis of where we have got to, and how he imputes to the Russian Government certain motives and intentions. No one is going to disagree with that analysis. In particular, in relation to sanctions, I reassure the noble Lord that the UK is looking at a package of broad and high-impact sanctions to raise the cost of any further aggressive actions. He is probably aware that we already have in place sanctions in respect of Crimea and the wider activities by Russia in relation to Ukraine. My understanding is that we currently have sanctions on 180 individuals in Russia and 48 entities for the destabilisation of Crimea and Sebastopol and eastern Ukraine. Those economic measures include restrictions on parts of Russia's finance, energy and defence sectors and trade and investment measures in place.

The noble Lord, Lord Campbell, also raised the position of Ukraine in respect of the Euro-Atlantic community and its legitimate right to seek to be part of that. That simply reaffirms what was agreed back in Bucharest, that NATO understood that both Ukraine and Georgia, as sovereign states, should have the right to determine what relationships they seek, and that is absolutely correct. He sought reassurance about unity of purpose within NATO. As I indicated to the noble Lord, Lord Tunnicliffe, particularly with reference to the recent NATO-Russia Council meeting, that unity of purpose is there.

In relation to the EU, yes, we support the Minsk agreements and the efforts by Germany, France and the Normandy Format to try to take matters forward. That has proved challenging, because Russia is declining to play its part in that. Indeed, one of the difficulties is that France and Germany have a role as mediators, and Ukraine and Russia have roles as parties to the conflict, but Russia refuses to accept that. That is proving to be a roadblock in the process. Indeed, I understand that, very recently, the European Council extended its EU restrictions on Russia. That suggests that the EU has a concern about the continuing situation.

[Baroness Goldie]

In conclusion, as the noble Lords, Lord Tunnicliffe and Lord Campbell of Pittenweem, have recognised, there is concerted effort by not just the United Kingdom but the United States, NATO, France, Germany and the EU to assist in the de-escalation of this tension, but there is a united desire to support the absolute, fundamental right of Ukraine to be treated with respect and correctly under international law as a sovereign state and not to find itself subject to threat and illegal incursions. That is something that the international community regards as fundamentally important, and it is why we will all work in unison to do our very best to support Ukraine.

7.55 pm

Lord Lancaster of Kimbolton (Con): My Lords, the noble Lord, Lord Campbell, outlined very clearly President Putin's intent. I also commend my right honourable friend Ben Wallace's article yesterday in the *Times*. Like all bullies, President Putin responds to only one thing, strength, and so I welcome yesterday's Statement. Equally, as NATO, we must not be seen to provoke Russia—let us be clear, President Putin will go a long way to be provoked—but nor is it our right to somehow negotiate away Ukraine's right to join NATO if it wishes to do so. If we have yet more requests from Ukraine for, potentially, weapons with which to defend itself or other training, will we maintain an open mind and support our ally in its time of need?

Baroness Goldie (Con): Yes, I reassure my noble friend that we will do everything we can to support Ukraine. As I said earlier, Ukraine is a friend and an important bilateral defence partner. In terms of the agreements it has reached in its own right, and legitimately so, with the international community and NATO, it has positions which should be respected. Like NATO, the UK will continue to review, assess and monitor, and we shall continue to respond, in conjunction with our allies, in the best way we can.

Lord Browne of Ladyton (Lab): My Lords, I welcome the Statement and particularly that, of its three pages, one is devoted to dialogue, which is the only way in which the dreadful current set of circumstances will be resolved. However, I am disappointed that, despite the fact that the paragraphs on dialogue begin with the sentence

"I must stress that no one wants conflict",

there is no recognition that there is existing conflict. There is conflict going on in the eastern part of Ukraine and, despite the refreshment of a ceasefire on 22 December, violations of that ceasefire continue. In fact, the OSCE Special Monitoring Mission to Ukraine's daily report for today says that it recorded, in the last 24 hours, 113 ceasefire violations in the Donetsk region. In the Luhansk region,

"the Mission recorded two ceasefire violations, including one explosion"

and 144 violations in the previous 24 hours. There is existing conflict going on and people are suffering. There are missing persons and all the aspects of violence that we have come to know in many countries across the world recently. My question for the Ministry of Defence, the Minister, the Secretary of State and the Government is: what are we doing to try to lessen or cease that violence for the people who are living with it daily? It is so bad that that amazing mine-clearance organisation, the HALO Trust, has had to suspend its work in the region at the moment.

Baroness Goldie (Con): The noble Lord makes a very important point. He is right that we should remember that a considerable part of Ukraine continues to be illegally occupied, with the negative and unwelcome consequences to which he referred.

The United Kingdom, as the noble Lord will be aware, has supported Ukraine for over 30 years since it became a sovereign state in its own right. Since 2015, through Operation Orbital the UK has done what it can to help build what I described earlier as the resilience of the Ukrainian armed forces. We have provided defensive training to over 22,000 Ukrainian troops since 2015. That includes the maritime training initiative, to which I referred, to help the Ukrainian navy rebuild its capacity.

In June last year we entered into an agreement with Ukraine through a memorandum of implementation, which affirmed the UK as open to supply Ukraine with defensive weapons systems as well as training. That principle remains. The noble Lord will possibly be aware that we signed a UK export finance treaty last November to finance the Ukraine naval capabilities enhancement project. That treaty amounts to £1.7 billion of assistance.

That is meaningful help and it might assist your Lordships to understand that this is not just empty rhetoric. The proposal is that there will be missile sale and integration on new and in-service Ukrainian navy patrol and airborne platforms, including a training and engineering support package. There is a going to be development and joint production of eight fast-missile warships with modern defensive armaments. We will also assist with the creation of a new naval base in the Black Sea as a primary fleet for Ukraine and a new base in the Sea of Azov.

What the UK is trying to do in a holistic manner is to come to Ukraine's aid in helping it to be more ready to defend itself. I think the UK can be satisfied with, and justly admired for, the help it has been giving. It has not been doing that alone, of course. As the noble Lord will be aware, the United States has been assisting as well.

The United Kingdom is very conscious of the extremely sensitive position in which Ukraine finds itself, not least because of the issues to which the noble Lord referred, but we are doing a number of very substantive things to assist it.

Lord Alton of Liverpool (CB): The Minister was right to emphasise the importance of respecting the sovereignty of Ukraine. In 1989, I was privileged to be in Lviv in Ukraine at the time of the pro-democracy rallies there, when they were trying to throw off the hegemony of the Kremlin. Does the Minister agree that part of the Putin narrative is the recreation of the Soviet Union and that his regime is pushing in every direction it can to try to achieve that?

I particularly welcome what the Secretary of State for Defence said yesterday in pointing to Vladimir Putin's 7,000-word essay, which has ethnonationalism at its heart. Only one paragraph mentions what the Secretary of State calls

"the straw man of NATO";

in other words, this is an excuse to talk about NATO when there is a whistle blowing from the Kremlin, trying to whip up ancient hatreds.

Are we western nations not in danger of falling into the Byzantine trap? The Byzantines, when they had the enemy at the gates, were arguing about the gender of angels. Is it not important that, despite the vested interests the West has in gas, oil and the rest, we stand together and recognise what the people of Ukraine fought for in 1989 in seeking their independence and stand with them at this terrible time of trial?

Baroness Goldie (Con): I think very few people would disagree with the noble Lord's sentiments and I thank him for his reference to the comments by my right honourable friend the Secretary of State. I think an earlier contributor mentioned his article in the *Times* yesterday. I thought it was an extremely helpful analysis and a very clear illustration that in the West we totally understand what is happening and see through it. I think there is a need for that candour and that rigour.

I feel that in the current situation there is a need to be absolutely focused on where the immediate threat lies. As we speak, something like 100,000 Russian military are amassed on the borders of Ukraine. That is the actual threat and that is why we have to address our thoughts to how best we support Ukraine with a variety of measures, whether that is what we were doing in supplying from the UK these weapons that can be used in a defensive capacity, whether it is that we propose to apply sanctions if anything unacceptable happens, or whether it is that NATO and the EU are united as to a response against anything that President Putin may be minded to do which, quite simply, is unacceptable, contravenes international law and is an affront to the independence and sovereignty of Ukraine.

Lord Lea of Crondall (Non-Afl): My Lords, just over 100 years ago, Europe descended into war when no one wanted that sort of escalation. On that or any similar analogy, how can you ever get into a mode of de-escalation, which the Minister referred to? I do not disagree with anything that has been said this evening, but I press her on the point that I am raising, which has not been addressed: how do the Government think that de-escalation can come about in any way, given the pride all around? In 1,000 years of Russian history, Ukraine was always part of the Kievan Rus, and Kiev is in Ukraine. There was also the Battle of Balaclava and *War and Peace*, which every Russian child has read. In this country, where I live, all the roads are named after Balaclava or somewhere else in the Crimean War.

Consistent with not playing chicken or being the one that looks scared, how can we get to practical de-escalation? That is a simple question, and I would like to hear a little more from the Minister on how we get to a scenario with a degree of de-escalation—or is that just a pipe dream?

Baroness Goldie (Con): It need not be a pipe dream, but it requires both a recognition by President Putin that he seems determined to pursue a provocative and dangerous route and an understanding by him that little—nothing—positive is to be gained by that and that he has to play his part as an international leader, which one assumes he wishes to be recognised as, and agree to enter into what the noble Lord, Lord Tunnicliffe, wisely alluded to: dialogue. I totally agree with the noble Lord that dialogue is the only way to address de-escalation. We require President Putin to play his part.

It is important to say that our divergence, as the United Kingdom, is with the Russian Government, not the Russian people. We have had a very happy history of sharing many things in common with them, but we certainly do not welcome the current relationship that has emerged in relation to the Russian Government, induced by the aggressive and provocative actions of President Putin. So I say to the noble Lord: it is difficult.

Yesterday, my right honourable friend the Secretary of State said in the other place that there is a "gap". It need not be unbridgeable. To echo what the noble Lord, Lord Tunnicliffe, said, we all have to use every ounce of energy we possess to keep trying harder to keep doors open and to persuade President Putin to understand that this route will not enhance Russia or be positive for him—and to understand that he should consider the legitimate position of Ukraine and agree to come to the international fora and discuss his concerns. That is what we are determined to try to encourage.

Lord Austin of Dudley (Non-Afl): My Lords, can the Minister assure us that the Government are drawing up a much tougher list of sanctions and asset freezes for anyone connected with Putin and his dictatorship—people in the Russian Government and parliament—including excluding Russia from the SWIFT banking system? Can she assure us that reports from the last few days that that is off the table are not true and that the international community will exclude Russia from the SWIFT banking system?

Baroness Goldie (Con): As I said earlier, the UK is looking at a package of broad and high-impact sanctions to raise the cost of any further aggressive actions by President Putin. I cannot comment on the detail of what these proposals are, but we are ready to act—and, as my right honourable friend in the other place indicated yesterday, we are not alone. A range of sanctions is available that are going to be enacted if there is any deterioration in the situation.

Lord Berkeley (Lab): There are terrible things going on in Belarus, between Belarus and Poland. I have some friends in the Baltic states who are reporting similar troop build-ups along the frontiers with Russia there. I suspect similar things are happening towards the south, east of the Black Sea. Are the Government aware of Mr Putin's attempts, shall we say, to recreate the old Union of Soviet Socialist Republics, and what are we doing about it? Are we just going to wait till it gets worse?

Baroness Goldie (Con): The activities of NATO in recent years have included a much more forward presence in the Baltic area, in which the United Kingdom plays an important part. We are alert, as is NATO, to anything which may compromise Euro-Atlantic security. If we are aware of any proposal which would compromise that security, we will, in conjunction with our allies and partners in NATO, consider how best to respond to that.

Viscount Stansgate (Lab): My Lords, a few minutes ago in Berlin, the Secretary-General of NATO, Jens Stoltenberg, said that the risk of conflict is real. Does the Minister agree? Can the Minister tell the House what discussions are being held by the British Government with NATO right now? In respect of what may happen in the future, I—like many noble Lords—worry about miscalculation. If President Putin makes the grave error of invading Ukraine, could the Minister comment on the possible risks that UK personnel, who have been helping the Ukrainian forces to train, might become embroiled in direct conflict with forces from Russia?

Baroness Goldie (Con): As has been made clear, we have a training presence in Ukraine, Operation Orbital. In respect of the announcement, the subject of this Statement, which my right honourable friend dealt with in the other place, it is very clear that we will have a small training presence for a short period of time in relation to the pieces of equipment that we are proposing to deliver to Ukraine. We are constantly in discussion with allies and with NATO. We recognise that that is the only, and best, way to try to ensure that everyone has the unity of purpose that was referred to earlier. That is extremely important.

Baroness Helic (Con): My Lords, I welcome yesterday's Statement. It is refreshing to see western unity when it comes to defending the sovereignty and territorial integrity of an ally. There is another country that is in the Kremlin's sights, Bosnia-Herzegovina, where the Russians are trying to open another front. Unfortunately, there is not the same unity in response. We have been lagging behind the United States in responding by applying sanctions, and our European allies are split down the middle, with some, such as Croatia, Slovenia and Hungary, openly supporting Russian interests in the Balkans. Will the Minister tell the House how we can work better with our allies, and show a unity of purpose regarding this country as well?

Baroness Goldie (Con): I reassure my noble friend that we take the situation in the western Balkans very seriously. We are regularly engaged with the western Balkan countries, not least with Bosnia and Herzegovina, and we have ministerial engagement on a regular basis with these countries. We try to ensure that we support resilience; we provide training and advice, and we try to do everything we can to encourage harmony and stability. I reassure my noble friend that there is very close communication with the western Balkan states, and we regard that as important, because the area is of strategic significance.

Health and Care Bill

Committee (3rd Day) (Continued)

8.15 pm

The Deputy Chairman of Committees (Lord Lexden) (Con): My Lords, in the next group of amendments, the noble Baronesses, Lady Brinton and Lady Masham, and the noble Lord, Lord Howarth of Newport, will be taking part remotely.

Amendment 47

Moved by ***Baroness Finlay of Llandaff***

47: Clause 16, page 13, line 38, at end insert—

"(ea) specialist palliative care services,"

Member's explanatory statement

This amendment would ensure that specialist palliative care services are a core service available equitably across all sectors.

Baroness Finlay of Llandaff (CB): My Lords, to state the obvious, everyone will die. On average, one person dies every minute, and every 22 minutes a child loses a parent. Dying patients are seen in every part of healthcare, and the vast majority will have some level of palliative care need. I declare my interest as a specialist in palliative medicine over decades, and my roles with different relevant hospice and palliative care charities and being employed through the Velindre Cancer Centre.

Amendment 47 would introduce a specific requirement for clinical specialist palliative care services to be commissioned by integrated care boards in every part of England. Amendment 52 is to inform the debate as it draws on the World Health Organization definition of specialist palliative care. These amendments are strongly supported by Marie Curie, Hospice UK, Together for Short Lives, Sue Ryder and the Alzheimer's Society.

Let me be clear; this is about specialist clinical services. General basic palliative care should be a skill of every clinician. But, until it is recognised as a core specialty, generic services will continue to view it as an extra and learning will not be integrated across all areas. Educating and training are crucial duties in upskilling others. In the pandemic, palliative care has been propelled centre stage as a driver of good practice. Specialist palliative care is a relatively new specialty, which is why it was not included in the early NHS legislation. The other truth, that everybody is born, was recognised by requiring every part of the UK to have maternity services. That has been reiterated in legislation and in Clause 16 of this Bill, along with dental and other services.

The hospice movement grew up outside the NHS, spearheaded by Cicely Saunders, who realised that bringing about change within the NHS was painfully slow. This has meant that a patchwork of services has developed in the wealthier parts of Britain. In some areas great, innovative integration with community social care is happening. But other areas of enormous need are left with almost no service, or no service at all. Now we depend on fundraising events for people to get expert support for pain and other symptoms, and for psychosocial distress. No one would advocate

to have a cake sale so that a woman in obstructed labour can have a caesarean section, so why turn a blind eye to ways to improve the quality of life of those with serious and life-threatening illnesses and support their families? Debate in the other place suggested that palliative care is aftercare; it is not. It is not an add-on just before death. It must be an integral part of care so that problems are dealt with in a timely way, not left to escalate into a crisis.

In Section 3 of the NHS Act 2006, clinical commissioning groups had the same general duties as in this Bill, yet significant gaps in specialist palliative care services persist between clinical commissioning groups. Some populations fare particularly badly: people who are homeless or in prison, BAME groups, Gypsies and Travellers, LGBTQ+ people, people with learning disabilities and those living in poverty, alone or with dementia. Yet the way a person dies lives on in the memory of those left behind.

Marie Curie's freedom of information requests to English CCGs revealed an average spend last year of as little as £19.02 per person aged over 65. Only 35% of CCGs responding offered specialist palliative care services in all care settings overnight and at weekends, yet such services are known to reduce pressure on NHS services and achieve savings by reducing the number of hospital bed days occupied and unplanned admissions.

Research from King's College London and supported by Marie Curie reveals that of the 23 integrated care systems in England with published strategies, only six identified palliative and end-of-life care as a priority area. Five mentioned broad bereavement support and only three identified relevant measures of success, such as reduced hospital admissions.

In the pandemic, many hospices hit financial instability head on as fundraising dried up. The government bail-out was essential, and I think that everyone was very grateful. In 2008, Wales had tackled this problem head on, aware that if a hospice folded, the clinical core service would still be needed. With just over £2 per head of population investment, we moved to provide core specialist clinical palliative care through an agreed funding formula, moving to seven-day services and 24/7 advice to any health or social care professional with a patient needing help. These services cover hospitals, hospices and community, with increasing integration reaching areas where no services existed. We instigated a paediatric service and an all-Wales unified patient record across the NHS and voluntary sector providers, which I described last week.

The outcomes that we achieved warrant consideration. To quote one nurse:

> "The patients have access to specialist palliative care nurses, advice and experience on the weekend, which is great, and if we weren't there, they wouldn't have that, and they'd suffer for it. Unfortunately, people deteriorate and die out of hours. They don't all die Monday to Friday, nine to five."

At the south-east Wales cancer centre, specialist palliative care is now embedded in the acute oncology service, whose audit revealed that almost three-quarters of the patients presenting to acute oncology had a level of unmet need in palliative care but were unknown to any services at the time. The majority then had same-day, face-to-face palliative care review or were referred to their local team. In the community last year, there were more than 3,700 patient contacts, over 1,000 being face to face. I remind the Committee that that covers a population of about 1.5 million. Many families have "just in case" boxes to make sure that medication is available, and the ambulance service can link in too.

For cancer centre in-patients, the palliative care audit showed that nine out of 10 symptoms improved during the patient's stay, including pain, breathlessness, constipation and weakness, and nausea scores fell to zero by day seven. Multifactorial drowsiness persisted in some whose disease was progressing rapidly to death.

In England during the pandemic, specialist teams were in place. They have shown that they can facilitate discharge, support staff having difficult ethical and communication dilemmas, and support patients and families, but a Marie Curie survey of carers of people who died at home during the pandemic found that 76% said that their loved one did not get all the care and support they needed, 64% did not get pain management and 65% did not get the out-of-hours care.

This Bill arrives at a critical moment for improving care. In 20 years' time, 100,000 more people will die each year in the UK. Demand is set to increase rapidly as our population ages and more people live for longer with multiple and complex conditions. The number of people dying with a need for palliative care is projected to increase by up to 42% by 2040. This cannot be left unaddressed, and the solution is at hand. I hope that the Government will finally recognise that they can improve care without increasing overall cost by adopting Amendment 47, to explicitly require the commissioning of specialist palliative care for local populations.

The NHS promised to support people from the cradle to the grave, and it can now realise that promise. I beg to move.

The Deputy Chairman of Committees (Lord Lexden) (Con): My Lords, the noble Baroness, Lady Brinton, is taking part remotely. I invite her to speak.

Baroness Brinton (LD) [V]: My Lords, I thank the noble Baroness, Lady Finlay, for laying these amendments and pay tribute to her for her tireless work in the palliative care sector and in your Lordships' House. I also thank Marie Curie, Hospice UK, Sue Ryder, Alzheimer's Society and Together for Short Lives for their very helpful briefing.

Clause 16 provides integrated care boards with duties to commission hospital and other health services for those for whom they are responsible. While specific services are highlighted in the clause, there is still nothing for specialist palliative care as currently drafted. There should absolutely be a fundamental right to access palliative and end-of-life care and support services for everyone who needs them. It is vital to restate that palliative care and end-of-life care are not always the same thing.

Hospices, homes and special services at home help children and adults for more than just those last few days. However, far too many people already miss out

[Baroness Brinton]
on palliative care, as the noble Baroness, Lady Finlay, set out; estimates suggest that while as many as 90% of people who die may have hospice and palliative care needs, only around 50% will actually receive it. Like many others, I am afraid I know family and friends who were desperate to move to a hospice in their last few days but ended up dying in hospital. In my stepfather's case it was because of the bureaucracy of the hospital—at the point at which they said it was possible to move him, they said it was too late.

If we can reduce unplanned and potentially avoidable hospital admissions, it would be considerably less distressing for the patient and their families and would also reduce pressure on our hospitals.

With people in the last year of their life in England accounting for some 5.5 million bed days, it is estimated that the total cost of these admissions is over £1 billion for our already pressed acute hospital trusts. I have a friend currently receiving end-of-life care who is also stuck in a hospital. The real problem is the lack of understanding of where and how the specialist services can be provided. That is vital, because otherwise people end up in hospital and cannot get out again.

During debate on a similar amendment in Committee in the Commons, the Minister of State for Health, Edward Argar, indicated that the Government's view is that everything is covered by aftercare. As the noble Baroness, Lady Finlay, said, this is not aftercare. If you have ever seen the brilliant work of palliative care specialists, you will understand that it is real care at a vital time in people's lives.

I mentioned Together for Short Lives in opening. I have a particular interest in children's palliative and end-of-life care. One of the things that worries me most at the moment is that people often do not understand that respite care for families looking after young children with very serious illnesses and disabilities has been a vital way of ensuring that they can have some sort of break. They often work 18, 19, 20 hours a day, sometimes with help at home but often, during the two years of the pandemic, with no help at all.

Take the example of my local children's respite centre, Nascot Lawn. The parents took the CCG to the High Court twice and won, but it closed down. It was not the first. Part of the problem we have with our hospices and other forms of provision is that they rely utterly on public fundraising. The last two years have been a particular problem. For children's respite and palliative care, it is an absolute tragedy—far too many units are closing down around the country.

In addition, despite a version of the language used in Clause 16, on aftercare, having been in place since the 2012 Act, many CCGs do not currently commission sufficient specialist palliative care. Worse, in the case of Nascot Lawn, the entire onus was put on the local authority because, it was said, it was about personal care. One of my concerns is a muddle between personal care and aftercare, when all these children required specialist nursing.

It is vital that the funding element is looked at. The noble Baroness, Lady Finlay, is right that the NHS always proudly boasted that it was there for people from the cradle to the grave. Sadly, at the moment this is not true. It is the hidden gem of our public health system and we must find a mechanism to make it not hidden but apparent and something that everyone who wants and needs it can rely on in the future.

8.30 pm

Baroness Masham of Ilton (CB) [V]: My Lords, I thank my noble friend for this important debate. I strongly support the amendments which would ensure specialist palliative care, which should be available for all adults and children across the country should they need it.

Marie Curie suggests that while as many as 90% of people who die have palliative care needs, only 50% currently receive palliative care. Research reveals that of the 23 integrated care systems in England which have so far published their strategies, only six have identified palliative and end-of-life care as a priority area, as my noble friend has stated.

After long years when my husband had complicated conditions after a stroke, it would have been very helpful to have had some palliative care at the end. He died on a Sunday. The doctor would not come out. He died with me, in an A&E department. The doctor and nurse did their very best, but it was impossible to see his medical notes and the poor doctor was in desperation. It was a difficult situation as he passed away. This is one reason why a plan with some palliative care would be helpful.

I saw the struggles that the parents had when a young cousin of mine aged seven had neuroblastoma. They did everything they could. He was treated in Germany and England; they took him to the Children's Hospital of Philadelphia, known for the treatment of neuroblastoma. He had spells in a children's hospice in Yorkshire and, when in remission, went back to school.

Such parents, of whom there are many throughout the country, need support. I ask my noble friend Lady Finlay, a professor of palliative care, whether this support for parents or nearest and dearest comes under palliative care? I hope that the Government will see that palliative care should be included in this Bill.

Lord Howarth of Newport (Lab) [V]: My Lords, while we all treasure the hospice movement and revere Cicely Saunders and her disciples, the grim fact is that there are all too many parts of the country where hospices are lacking and, as the noble Baroness, Lady Finlay, explained, palliative care is limited and inadequate, or perhaps even non-existent. Of course, palliative care, available in every setting, must become a core responsibility of the NHS. We should not displace the hospices and the charitable ethos, but where hospices do not exist—mainly in poorer communities where fund-raising capacity is small—default provision should be made by the NHS. These amendments would secure universal availability of high-quality palliative care.

High-quality palliative care is, of course, not just a matter of technical skills in pain relief and so on. Dr Iona Heath, a past chair of the Royal College of General Practitioners, has written:

"The whole discipline of medicine has colluded in the wider … project of seeking technical solutions to the existential problems posed by distress, suffering and the finitude of life and the inevitability of ageing, loss and death. Sickness and death have

gradually come to be regarded as failures of medicine, even by doctors themselves, rather than inevitable constituents of what it is to be human."

At a round table on the arts and palliative care, dying and bereavement convened by the All-Party Parliamentary Group on Arts, Health and Wellbeing and chaired by the noble Baroness, Lady Finlay, Dr Viv Lucas—medical director of the Garden House Hospice, Letchworth—said that the role of doctors in this context is not to cure disease but to heal their patients. She said that this implies

"addressing the subjective experience of human suffering and facilitating a process of inner change—not about the technological doing to of the disease-orientated model but of being with, bearing witness."

The hospice movement acknowledges creative work to be a vital human activity. Through the arts, we can transcend suffering, come to terms with our own mortality and enable our own healing. Artist Virginia Hearth has said:

"The arts offer us a way of making sense of the world and help us to define who we are and who we have been."

There is an abundance of evidence cited in the World Health Organization scoping review of the benefits of the arts in end-of-life care, through opportunities for communication and emotional expression, reframing of the illness experience, and enhanced human connection.

Equally, the arts can help families watching their loved ones approach death and afterwards. At another APPG round table, the director of Grampian Hospitals Art Trust, Sally Thomson, read out a letter from a woman whose husband had been diagnosed with terminal cancer:

"To be given a terminal prognosis is devastating for both the patient and family. To take away your future, the opportunity to grow old and grey with your spouse and to watch your children grow and thrive. You lose your independence and your sense of self, your purpose and role in life. Yet in the midst of this suffering lies the Artroom. An oasis of positivity and fulfilment providing a different purpose. One of creativity and self-expression. It is a place where the self is rediscovered and allowed to flourish … It's medicine for the soul and every bit as vital as drugs and chemotherapy. A life-fulfilling experience that has changed both our lives for the better."

As Dr Rachel Clarke, a palliative care doctor, writes in her beautiful book, *Dear Life*:

"What I witness, over and over, in the hospice … is that there is nothing more powerful than another human presence … reaching out with love and tenderness towards one of our own."

Lord Patel (CB): My Lords, I support Amendment 47, to which I have attached my name. I thank the noble Baroness, Lady Finlay, for her brilliant introduction to these amendments, and the other three speakers who spoke so passionately. We have debated this issue several times, and the time has now come that we should be angry about it. The time has come that we should have palliative care and hospice care being made a part of the NHS as a commitment on the face of the Bill.

I shall read the words of a government Minister in *Our Commitment to You for End of Life Care—The Government Response to the Review of Choice in End of Life Care*. The Minister, Ben Gummer, then Parliamentary Under-Secretary of Health, said this:

"A universal provision of good care will make possible what we should expect from our health and care system - a universal expectation of a good death."

He went on to say:

"Cicely Saunders was articulating an ancient truth when she described her mission: that 'we should see the last stages of life not as a defeat but as life's fulfilment'. A good death - peaceful, dignified, reflective, compassionate, in the loving embrace of those closest to the dying person - is already a happy end for hundreds of thousands of people across our nation."

The next line is important:

"In making this commitment, we make that promise universal, so that every dying person in England can live in anticipation of a good death."

I ask the Minister: when that was written in 2016, was it an empty promise or is it likely to become a reality now?

We do not sufficiently value care for those for whom there is no cure. We do not value the short lives of children and young people who die prematurely and who will never be parents, let alone grandparents. Some Members here may have attended the annual reception held downstairs for parliamentarians by Together for Short Lives and other charities. They are attended by children and young people from the ages of three to 16, some using crutches, some using wheelchairs, some with tubes in their noses to supply oxygen, some undergoing IV treatment and some with IV pumps to relieve the pain. It brings tears to your eyes when you see them, but they all come with smiles on their faces, grateful for the care that they get—professional and dedicated care from professionals and volunteers.

So why do we rely for three-quarters of the funding for palliative and hospice care on the charity sector? Why is it that the Government fund only one-third of the care? Why, as the noble Baroness, Lady Finlay, said, do these charities have to sell cakes at village fêtes and second-hand books, toys and clothes for the money that they so fervently raise? Why can we not find the money?

Sue Ryder commissioned research into the total costs required to fund palliative and hospice care for every patient that needs it. They come to about £987 million a year. I should imagine that the transaction costs of the reforms that we are debating in the Health and Care Bill will probably cost several billion pounds. So it is possible for us to reorganise the health service at a cost of billions of pounds, but we cannot fund end-of-life care for those who are dying—children, young people and older people. We should be ashamed of that.

The Lord Bishop of Carlisle: My Lords, it is always a pleasure to follow the noble Lord, Lord Patel. I am pleased to give my wholehearted support to Amendment 47 and to Amendment 52, to which I have added my name, which compellingly requires the commissioning of specialist palliative care services in every part of England. Throughout my life and work I have often had the privilege of being present with families and communities, supporting people of all ages through the final chapter of their life, so I have seen at first hand the enormous difference that high-quality palliative care can make to their experience of dying, death and bereavement.

However, as the noble Baronesses, Lady Brinton and Lady Masham, pointed out, 90% of people might need such care, but as things stand at present only

[The Lord Bishop of Carlisle]
about half of them will receive it. What is more, it is all too often those in our most deprived communities who are dying without the help and dignity they deserve.

8.45 pm

To that end, a compelling body of evidence has been provided by Marie Curie, the end-of-life charity, which has been mentioned several times already in this debate. Building on that evidence, this amendment will not only prevent many people with a terminal illness dying in pain but deliver significant cost savings to the NHS by reducing unnecessary hospital admissions.

I believe that the Bill provides us with a great opportunity to improve palliative care for everyone. As we have heard, Clause 16 explicitly mentions several services that ICBs are required to commission—for instance, maternity and dentistry—but as the noble Baroness, Lady Finlay, made clear, it makes no direct reference to improving care and support for people living with a terminal illness.

It is also the case that, as we heard, of those 23 integrated care systems that have already published their strategies, only six have mentioned end-of-life care as a priority. That in itself speaks volumes. Yet we have been reminded that, as a result of our ageing population, in 20 years' time there will be about 100,000 more people dying each year. The need for good palliative care will increase rapidly in years to come. This amendment will help ensure that the demand is met.

This amendment has attracted a great deal of support from professionals and the public, as well as providers. I urge the Government to accept it as a vital part of our commitment to care for everyone from birth to death, and to ensure that all have the best possible end-of-life experience, regardless of where they live.

Baroness Meacher (CB): My Lords, it is a great pleasure to follow the right reverend Prelate the Bishop of Carlisle. I give my very strong support to Amendment 47, to which I added my name, and Amendment 52. The key arguments have been extremely powerfully made by the noble Baroness, Lady Finlay, and others.

My main concern is to make it abundantly clear that I and everyone I know who supports assisted dying also want to see the highest possible quality of palliative care across the country—not some kind of patchwork, but universally. I, like all noble Lords, have witnessed wonderful palliative care but also what I might describe as substandard care of dying people. The difference to the patient and the relatives is unforgettable for everybody involved. I visited a beautiful hospice with a warm and professional atmosphere recently, but there were empty beds because it had not been able to raise enough money from whatever it was—jumble sales, et cetera. It is entirely unacceptable that hospices are expected to raise funds to provide their services.

As I said, I also support Amendment 52, which details the types of services that must be provided as part of this country's commitment to providing accessible and excellent care. The inclusion of the definition of palliative care as provided by the World Health Organization would ensure statutory recognition for this most important aspect of healthcare.

Finally, we need to accept that top-quality palliative care must involve patients' wishes being understood and respected. Patient choice is more and more accepted throughout the NHS, but it is most important at the end of life. Central to top-quality palliative care will be the right of patients ultimately to decide how much suffering they wish to bear and when they have had enough. The lack of control under the current law will inevitably undermine the patient experience of palliative care, however devoted the staff.

The great majority of dying patients will die naturally, even when assisted dying becomes lawful. However, the great majority of dying people will live and die better knowing that they will have some control when it really matters—when their suffering is no longer bearable.

Lord Hunt of Kings Heath (Lab): My Lords, whatever view we take on assisted dying, I think that there is general agreement that the noble Baroness, Lady Finlay, deserves a great deal of support in her two amendments. The predicament that we find ourselves in is that the Minister will probably reject them and say that the Government will ensure that the NHS prioritises these services in the future. The trouble is that we have been here many times before, as the noble Lord, Lord Patel, said. He mentioned 2016, but in 2015 the *Economist* produced its last quality of death index, as far as I can find out, which basically said that the UK had the best palliative care in the world, but it was very patchy. I am afraid that the situation has simply not moved on.

So the question is: what should we do? Clearly, it is not going to get better if you leave it to the health service. It treats hospices dreadfully, with continuous late contract signing and short-term contract signing by bodies that should be able to agree three-year rolling contracts with those institutions. The lack of priority that is given suggests to me that, unless we take legislative action, we will not see any improvement at all. That is the quandary for us in terms of collectively agreeing a way forward that makes it clear to the NHS that time is up on its neglect of palliative care. We really must take action.

Baroness Hodgson of Abinger (Con): My Lords, I too have put my name to these amendments, so ably introduced by the noble Baroness, Lady Finlay of Llandaff. Because this is the first time that I have spoken at this stage of the Bill, I remind your Lordships to refer to my Second Reading speech and entry in the register of interests for my experience and links around the topic of health. The hour is late, so I shall try to be very brief.

Although Clause 16 currently lists a number of services that the ICBs are required to commission, it fails extraordinarily to include palliative care. We have already heard that current estimates suggest that, although as many as 90% of people who die have a palliative care need, only 50% currently receive that care—only half. I find it somewhat horrifying that, as the noble Baroness, Lady Finlay, told us, a Marie Curie survey found that 64% of people who died at home did not get adequate care, with pain management.

Like others who have spoken, I know from personal experience of family members how hard it was for them to get the care they needed at the end of their life.

I am sure that everyone here can share examples of exceptional local hospices, especially facing the challenges of the pandemic, that currently have to fundraise to be able to do the work to fill these gaps—as the noble Baroness, Lady Finlay, told us, they sell cakes. It is quite extraordinary. I pay tribute to the outstanding work of the hospices and the wonderful palliative care doctors for the amazing support they give to those who are dying and their families.

Although I recognise the Government's concerns about overprescribing the list of services that integrated care boards should commission, it seems anomalous for the Bill to proceed with priority given to ensuring that ICBs commission maternity and other services but have no explicit requirement to commission palliative care services. I am sure that this was not the Government's intention, but I am concerned that the current drafting implies that health services for people at the end stage of their life are less important than health services for people at earlier stages. Surely the end of life is one of the times when care is needed most. I find it extraordinary that we are even having this discussion.

The addition of these amendments offers a unique opportunity to ensure that nobody with a terminal illness misses out on the care and support that they need, both now and in the future. I look forward to hearing the Minister's views on these amendments, which will help us to ensure that all of us have the end-of-life experience that we would hope and wish for when our time comes.

Lord Scriven (LD): My Lords, if we were having this debate about any other service in the NHS, people would be aghast. Can noble Lords imagine the response if we said that your access to dental treatment would be determined by the number of books sold; that your access to maternity services would be based on the number of jumble sales held; or that, ultimately, your access to ophthalmology would be dependent on the number of cakes and coffees sold at an afternoon party? These examples are no different from that of specialist palliative care, a service that is meant to be from cradle to grave. The unfortunate reason why the noble Baroness, Lady Finlay of Llandaff, has had to table her amendment, supported by other noble Lords, is that, for too many years, promises have been given but the services have not been delivered because the NHS does not commission parity of service across England.

I know quite a lot of people who work in the health service who are decent, hard-working and genuine, but the fact is that palliative care is seen by too many as an add-on and not central to the services they are providing. I do not blame them for that because, unfortunately, that is the behaviour that sometimes happens when the NHS does not have a mandate to provide specialist palliative care and people think that the local charity shop funds it. The noble Baroness has had to table Amendment 52 because we need to be clear about what this service is. It is not about just those last few days or weeks; it is not about just putting someone in a hospice. It is about giving psychological and medical care and support throughout a whole process to people with a life-threatening illness or who are at the end of life. This service needs to be commissioned against a clear understanding and definition of specialist palliative care.

I agree with many noble Lords: people across this country have waited far too long for access to specialist palliative care funded by the taxpayer. This does not mean that some of the charitable work would not continue, but such care should be a right and a service, funded by the taxpayer, which says that people will be looked after from cradle to grave.

Baroness Hollins (CB): My Lords, I applaud my noble friend's continuing persistence and commitment in seeking proper recognition of the role of specialist palliative care within our health and care services. I speak with around 40 years of clinical and clinical academic experience, first in general practice but mostly in psychiatry, and as a past president of the British Medical Association. Cicely Saunders taught me as a medical student, and she inspired my interest in this area.

Other noble Lords have stressed the shortfalls—I will not repeat them—but we know too that certain groups face significant barriers in accessing palliative and end-of-life care. Marie Curie's *A Place for Everyone* report found that this included people living in poverty, alone or with dementia, as well as people with learning disabilities. My own research in clinical practice has included a focus on end-of-life issues, including decision-making, for people with learning disabilities and autistic people. Most people with learning disabilities still do not get equitable end-of-life care, despite over a decade of inquiries and recommendations.

Personalising end-of-life care for everyone is in the *NHS Long Term Plan*. It must surely be enshrined within the duties of the ICSs. We have already heard about King's College's findings of a shocking lack of planning by the vast majority of ICSs. That is a problem; it cannot be left to chance. The truth also is that depression and anxiety are quite common among both those who are dying and those who are bereaved. From my perspective as a psychiatrist, I would say that we need palliative and end-of-life care to improve the experiences of both children and adults who are becoming bereaved. We know, for example, that adverse bereavement experiences in children, such as watching a family member dying in pain, are a predictor of difficulties in adulthood, in addition to affecting their educational achievements.

To achieve a comfortable death, it is imperative that the psychological distress of both the person who is dying and their nearest and dearest is understood and attended to, as well as any physical symptoms. This amendment should need no further discussion. Cicely Saunders would be horrified. I hope that the Minister will accept it. It would be a false economy not to go ahead with this provision.

9 pm

Baroness Fraser of Craigmaddie (Con): My Lords, I support both these amendments, and I refer to my interests as laid out in the register as a trustee of the Neurological Alliance of Scotland and chair of the Scottish Government's National Advisory Committee for Neurological Conditions.

There is evidence, as we have heard, that people provided with early palliative care and support in all settings, as is laid out by Amendment 52, achieve better

[Baroness Fraser of Craigmaddie]
outcomes and, as the right reverend Prelate the Bishop of Carlisle said, that it prevents unwarranted hospital admission. I would commend the Minister to look at the model in Scotland, where the Scottish Partnership for Palliative Care brings together health and social care professionals from hospitals, social care services, primary care, hospices and other charities to find ways of improving people's experiences of declining health, death, dying and bereavement.

Perhaps what differentiates palliative care from just good care is the awareness that a person's mortality has started to influence clinical and more personal decision-making. However, I beg to disagree with the noble Baroness, Lady Finlay. This is not about the fact that we are all going to die; it is about life. It is about the care of someone who is alive—someone who still has hours, days, months or years remaining in their life. It is about optimising well-being in those circumstances.

A major problem for people who need and would benefit from specialist palliative care is that they are often referred very late to such services or not referred at all, because such services are erroneously perceived by many other professionals, and the public, as relevant only at the end of life. Unfortunately, access to specialist palliative care is therefore not available to people dying with neurological conditions. Although there has been some progress, most people dying with terminal or progressive neurological conditions die under the care of generalist health and social care teams, in hospitals, care homes or at home. The recent research by Marie Curie, quoted by many noble Lords this evening, points out the patchy access to palliative care, and people with neurological conditions are overrepresented in not being able to access it.

There is a very high level of unmet need. As the noble Lord, Lord Patel, mentioned, we should be angry that end-of-life care is not available—and on behalf of people with neurological conditions, I am angry. For those who are receiving support from generalist teams, we know that hospital beds and suitable care packages are extremely scarce, especially as the health and care system seeks to cope with the Covid pandemic and its impact. As a result, we have a problem, and people are facing the end of their life without the support they require.

In a caring society, palliative care should be embedded into this Health and Care Bill. It should be a core service, available to all those who need it. I urge the Minister to support these amendments.

Lord Kakkar (CB): My Lords, I intervene briefly to support the amendment moved by my noble friend Lady Finlay. In so doing, I would like to put a question to the Minister. In the context of contemporary, 21st-century delivery of healthcare, how can it be justified that palliative care is not considered part of the continuum and has to be funded in a different way? How can it be that those specialists delivering palliative care are unable to integrate it into the broader considerations of delivery of healthcare in their institutions and systems? It seems completely counterintuitive that that continues to be the position in our country. If Her Majesty's Government were minded not to support these amendments, it would be helpful to understand how they justify that position and justify differentiating palliative care from other services that are rightly fully funded by the state.

Baroness Walmsley (LD): My Lords, I feel honoured to be a fellow Member of this House with the noble Baroness, Lady Finlay, because of her professional and political work in raising this issue before your Lordships.

I want to use a word that has not been used yet in this debate, and that word is "fear". The noble Baroness, Lady Fraser, nearly used it when she said that people are scared. Anybody who has read the reports that say that only 50% of people who need palliative care receive it will feel fear: "Is it going to be painful?", "Am I going to be able to bear it?" and, on the part of the carer and family members, "Is it going to be terrible for my loved one?", "Am I going to be able to help them?", "Am I going to be able to cope?" The physical pain is part of it, but, as the noble Baroness, Lady Hollins, said, the fear and the psychological distress make things a great deal worse. At a time when it is in our power to give people a good death, we are not doing it; that is a disgrace.

Baroness Merron (Lab): My Lords, I think it is fair to say that the debate today across your Lordships' House has shown that it is impossible to understand how specialist palliative care can be regarded in any logical, practical or humane sense as something so different. I am sure that the Minister will do his very best to address that in his consideration of these important amendments.

I am grateful to noble Lords for making this debate possible by bringing forward these amendments and making sensitive, informed and often personal contributions to underline the need to ensure that specialist palliative care features in the Bill. I am particularly grateful to the noble Baroness, Lady Finlay, for setting out the fact that if we are to say that the NHS is cradle-to-grave, that must absolutely shape how we approach such services. The noble Baroness and others, including the right reverend Prelate, talked about inequality and the fact that, when we speak of specialist palliative care, inequalities are not just in the course of someone's life but actually to the very moment they leave this world. That really had an impact on me, because that surely is an unfairness too far for us to just stand by.

Taking action could not be more pressing a need. We know that the UK's population is ageing rapidly. The Office for National Statistics predicts that, in 20 years' time, there will be twice as many people over the age of 85, while Marie Curie's analysis for Cardiff University has concluded that the number of people needing palliative care will rise by 42% by 2040. This is a challenge to our society which will not go away. As the noble Lord, Lord Patel, said, we should be able to live our lives in anticipation of a good death. The right reverend Prelate spoke of the difference of witnessing a good death, as opposed to a death that is less than what it should be.

It is important to say that, even before the pandemic, experts at the Royal College of Physicians, the Care Quality Commission, the health service ombudsman and Compassion in Dying were all sounding the alarm

on how those approaching the end of their life, and their loved ones, did not, in so many circumstances, feel supported to make the decisions that faced them and that it was impossible to turn away from. They did not know what choices were available, and, sadly, were not given an honest prognosis.

The amendments in this group offer dignity to the greatly increasing numbers who will need this care, and would bring in moral and well-evidenced measures essential to providing the tailored care that is needed in the final stages of one's life. This includes sharing information about a person's care across the different professionals and organisations involved in that care, and providing patients and their loved ones with specialist advice, 24 hours a day, every day of the week—which expert practitioners, including those at Cicely Saunders International, have been crying out for.

My noble friends Lord Hunt and Lord Howarth, the noble Baroness, Lady Finlay, the noble Lord, Lord Patel, and others underlined the work, role and contribution of the hospice movement, and also spoke about their incredulity at the reliance on charitable funding. Who in this Committee can be surprised at that feeling? I hope the Minister will be able to speak to that absolutely crucial point because, even before the pandemic, many hospices were suffering from poor decisions from clinical commissioning groups, poor practice, and a lack of support and recognition of the vital role that they play. That impacts on the individuals who so sorely need their services.

Marie Curie reported that 76% of carers who lost a loved one during the pandemic felt that they did not get the appropriate care that they needed. This is an opportunity to fix the problem. Every day, pandemic or none, the quality and personalisation of specialist palliative care will dictate how dignified and comfortable —or not—the end of a life will be, and how much of a burden will be borne by the carers and loved ones: whether, as the noble Baroness, Lady Hollins, reminded us, those left behind are adults or children. These amendments seek to get it right, and the feeling of this Committee could not be clearer. I look forward to the Minister's response.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord Kamall) (Con): My Lords, as we reach the closing minutes of today's debate and reflect on the wonderful contributions from across the Committee, perhaps it is fitting that we also talk about the final chapter of life, as the right reverend Prelate the Bishop of Carlisle said.

I thank all noble Lords who spoke very movingly today, particularly the noble Baronesses, Lady Meacher, Lady Hollins and Lady Walmsley, the noble Lord, Lord Patel, and my noble friends Lady Hodgson and Lady Fraser, who spoke about their own experiences. I also thank the noble Baroness, Lady Merron, for pointing out the 42% figure, which is very important to recognise. I thank the noble Baroness, Lady Finlay, for the engagement we had prior to this debate and for her helpful engagement with our officials and the Bill team. I hope that will continue.

What is interesting about this is that when I was younger, we as a society found it very difficult to talk about death. I was once told by my parents that the British find it very difficult to talk about death, except in faith groups. It is interesting that, over time, as we have become an ageing society, we are talking, as a matter of fact, about death. We talk about our wills, financial planning, and planning for care at the end of our life. It is appropriate that we recognise this. The fact is that, nowadays, when we look at the hospice movement, we do not think of it as a quaint little service or a charity; we think that it provides an essential service to help someone at the end of their life, and we recognise the difference between palliative care and end-of-life care.

I hope that I can reassure the Committee that the Government are committed to ensuring that people of all ages have the opportunity to benefit from high-quality, personalised palliative and end-of-life care, if and when they need it. I also pay tribute to the noble Lords, Lord Howarth and Lord Scriven, for their contributions. The noble Lord, Lord Howarth, talked about the role that the arts play in helping those at the end of their life, which he has talked about in a number of discussions we have had on this issue. Like the noble Lord, Lord Scriven, he made the point that while you want to see the state do more, you do not want to push or squeeze out the hospice movement, as we need the right balance.

9.15 pm

As the Government see it, the integrated care boards should take on, and are taking on, the commissioning of palliative care once they replace CCGs. That is because palliative care is already part of the comprehensive health service under new Section 3 of the NHS Act 2006, which lists the services that ICBs will be required to commission.

Palliative care is—as noble Lords have acknowledged —a broad term, describing the various elements of care provided to minimise suffering and optimise the quality of life for people with a life-limiting illness. Those elements of care include hospital or other accommodation, medical services, nursing services and other services for the care of persons suffering from illness. These are things that an ICB already has a duty to commission under new Section 3 of NHS Act 2006, inserted by Clause 16 of this Bill.

The right reverend Prelate the Bishop of Carlisle said that not all ICBs have been explicit about what they are doing in terms of commissioning palliative care. I will take that point back to the department, and I thank him for making me aware of it.

The Government's concern is that by adding palliative care, and specialist palliative care, as a separate element of Section 3, we risk the unintended consequence in law that the existing services in Section 3 do not already include palliative care. Nursing services absolutely should include nursing services for people receiving palliative and end-of-life care, including specialist palliative care. Medical services absolutely should include medical services for people receiving palliative and end-of-life care, including specialist palliative care. This amendment therefore risks inadvertently implying that some services are not already captured or should not be covered in more generic terms, an outcome that none of us would want. I pledge to noble Lords that I will look at this in more detail.

[Lord Kamall]

I also assure the noble Baroness that ICBs will be required to have regard to the National Institute for Health and Care Excellence guidelines in their provision of services, as CCGs currently are.

The noble Lord, Lord Kakkar, asked what the Government are doing to ensure that best practice is followed and spread. NHS England will continue to support commissioners of palliative and end-of-life care services through their palliative and end-of-life care strategic clinical networks. These networks support the delivery of outstanding clinical care by ensuring palliative and end-of-life care is personalised for all.

I am deeply grateful for the work of the noble Baroness, Lady Finlay of Llandaff, in advocating for these important issues. I hope that I can reassure your Lordships that the Government are approaching them with the seriousness they deserve. Having said that, I hear the concerns from noble Lords—indeed, the word "anger" was used—and I hope that the noble Baroness and other interested noble Lords will continue to engage with the department and my officials between now and the next stage of the Bill. Even though I understand the sincerity and deep feeling of the noble Baroness in laying this amendment, I hope in the spirit of offering further conversations that she will feel able to withdraw it.

Baroness Finlay of Llandaff (CB): My Lords, I am most grateful to everyone who has spoken tonight and who shared their personal experiences and the passion and, indeed, anger that my noble friend Lord Patel referred to. Really, we are at the point where enough is enough. I would love to address every point individually. I greatly appreciate the Minister's commitment in giving me access to his Bill team and to officials previously and I will take up that invitation with zeal because I will come back to this on Report. I can say now that I will divide the House on Report because enough is enough. We cannot carry on with the lack of action and the continued jumble sales, cake sales and everything else.

The noble Baroness, Lady Masham, asked me about the support for children. As the noble Lord, Lord Patel, pointed out, the cost of putting this right, if you work it out, is less than £20 per person across the population. It is really low. Yes, of course, it involves children. I would like to finish with a tribute to a little boy called Stevie. Stevie told me that he was going to die when his goldfish died. His goldfish died. He then asked that we promise not to give him any more injections. We said: "Fine, we will not give you any more injections, Stevie, we will keep everything controlled." His third point was for his parents to come in. He made them sit down and hold hands across the bed and promise to never argue again. He died shortly afterwards.

For all those children, all those adults—all those thousands of people—who are dying every minute, we must make sure that we meet their promises, that we give them good care and that they have good symptom control and good psychosocial support as they are dying and that their families do as well. Enough is enough. On that note, I beg leave to withdraw the amendment.

Amendment 47 withdrawn.

Amendments 48 and 49 not moved.

House resumed.

House adjourned at 9.21 pm.