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By,
Tom Powell

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Health and Care Bill: Committee stage report

Summary

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Summary

The Health and Care Bill 2021-22 was presented in the House of Commons on 6 July 2021.

The Bill takes forward recommendations for legislative reform in the NHS Long Term Plan (January 2019) and the White Paper, Integration and Innovation: working together to improve health and social care for all (510KB, PDF), published in February 2021.

The Bill would develop the 42 existing Integrated Care Systems (ICSs) by creating an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) as statutory bodies in each ICS area. The ICB will lead on integration between NHS bodies and the ICP will focus on integration between the NHS, local government, and other providers.

The Bill formally merges NHS England and NHS Improvement, and makes changes to procurement and competition rules relating to health services.

The Bill also includes proposals to give the Secretary of State for Health and Social Care powers to direct NHS England and to decide how other health services are organised. It gives the Secretary of State powers to transfer functions between some of the 'Arm's Length Bodies' that lead, support and regulate healthcare services in England, and to intervene in proposed changes to the way health services are delivered.

The Bill doesn't cover wider reforms of the social care and public health systems, although it does provide for some changes in these areas (and ICSs are intended to improve coordination between the NHS and local authority services).

The Bill

As it was originally presented to Parliament in July 2021 it had 135 substantive clauses and 16 Schedules [Bill 140, 6 July 2021 (928KB, PDF)]. The Government has produced a new version of the Bill reflecting the amendments made in the Public Bill Committee [Bill 183, 2 November 2021]. Including the four new clauses introduced at the Committee stage the Bill now has 139 clauses.

Second reading debate

The Bill's second reading in the Commons took place on 14 July 2021.

The Government said the Bill builds on the NHS's own proposals for reform, aiming to make it less bureaucratic, more accountable, and more integrated, and that it has incorporated lessons learnt from the pandemic.

Introducing the Bill, Sajid Javid set out some detail on the main measures and themes, including better integration. He said the Government recognised the desire for joined-up services, which had worked well for non-statutory integrated care systems:

> They have united hospitals and brought together communities, GPs, mental health services, local authority care and public health, and it works. We recognise that there are limits on how far this can go under the current law, so this Bill will build on the progress of integrated care systems by creating integrated care boards and integrated care partnerships as statutory bodies. England's 42 ICSs will draw on the expertise of people who know their areas best. They will be able to create joint budgets to shape how we care for people and how we promote a healthy lifestyle.

Reflecting on his recent appointment as Secretary of State, Sajid Javid also said he would continue to listen to the views of organisations involved, such as the NHS Confederation and the Local Government Association, and parliamentarians.

Responding for Labour in the second reading debate, the shadow Health Secretary Jonathan Ashworth said the Bill did not address the challenges facing health and social care. He said the Secretary of State was embarking on a "top-down reorganisation when we are not even through the pandemic…". He added that while NHS leaders had asked for a simple Bill "to get rid of the worst of the Health and Social Care Act 2012", the new Bill was a "power grab" by the Secretary of State.

Labour set out several specific concerns, including that new ICS structures would sideline mental health and public health, with no guarantee these services would be represented on ICBs. A number of Opposition members highlighted that the Bill had nothing to say about wider social care reform.

Committee stage

Committee stage began on 7 September 2021. It comprised four sessions of oral evidence and 20 sessions of line-by-line scrutiny over 10 days, concluding on 2 November 2021.

151 amendments and 70 new clauses (302KB, PDF) were tabled. Amendments 10 to 16, 117 to 121, and 147 to 148, and New Clauses 59 to 62 were all introduced by the Government and were subsequently added to the Bill.

While many Government amendments made technical changes, the new clauses would have the following effect:

- To put a duty on the Care Quality Commission to carry out reviews and assessments into the overall provision of NHS care and adult social care services within each ICB area (New Clause 59);
- To create a new power for the Secretary of State to intervene where local authorities are failing in the exercise of functions under Part 1 of the Care Act 2014 (adult social care) and make consequential amendments (New Clause 60);
- To remove the Care Quality Commission's power (under section 50 of the Health and Social Care Act 2008) to give an English local authority a notice of failure for not providing a service (New Clause 61); and
- To provide for circumstances where community pharmacies and other dispensing services do not have to be paid to supply medicines because stocks have been centrally purchased by the NHS (community pharmacists and dispensing doctors are usually paid to cover the cost of purchasing the medicines they dispense) (New Clause 62).

Amendments and new clauses were tabled by the Opposition and other members of the Public Bill Committee on a wide range of issues, none of which were accepted.

Commitments to Government amendments at Report

At some points during the Committee stage, the Minister of State for Health, Edward Argar, committed to consider the issues raised further. In response to concerns about private sector involvement on ICBs, the Minister committed to bringing forward an amendment at Report, to prevent individuals with significant interests in private healthcare from sitting on ICBs.

The Minister confirmed plans to bring forward legislation to ban 'virginity testing' after this issue was debated in Public Bill Committee. On the 18 November 2021 several Government amendments were tabled for consideration on Report. These amendments seek to create a number of offences in relation to virginity testing (see Health and Care Bill: Notices of Amendments as at 18 November 2021 (287KB, PDF)).

On 17 November 2021, the Government published details of its plans to cap adult social care costs from October 2023 (see Gov.uk, Adult social care charging reform: further details). On 18 November the Government tabled a New Clause for consideration on Report which would amend the Care Act 2014 to implement these capping arrangements. This would mean the costs accruing towards the cap are costs incurred by an adult (at the local authority rate), rather than the combined costs incurred by both the adult and the local authority (for further background on the issues raised by this announcement see BBC News, Government changes rules on social care cap, 18 November 2021).

Further reading

Background to the Bill, commentary on its provisions and responses from the sector can be found in the Commons Library briefing on the Health and Care Bill 2021.

The following official documents provide more information about the Bill:

- Explanatory Notes to the Health and Care Bill, Bill 140 EN 2021-22, 6 July 2021 (1,629 KB, PDF)
- Gov.uk, Delegated Powers Memorandum, 6 July 2021
- Gov.uk, Health and Care Bill: combined impact assessments, 13 September 2021

The King's Fund has published a briefing on the Bill ahead of Report stage, which provides information and views on some of the proceedings in the Public Bill Committee:

- Briefing on the Health and Care Bill: House of Commons report stage and third reading, 16 November 2021

The Commons Library briefing Death certification and medical examiners includes the Public Bill Committee consideration of the clause relating to medical examiners (Clause 124).

Information on legislative consent for the devolved legislatures can be found below:

- Scottish Parliament, Legislative Consent Memorandum
- Welsh Parliament/Senedd, Legislative Consent: Health and Care Bill
- Northern Ireland Assembly, Official Report relating to Legislative Consent Motion, 15 November 2021

1 Committee stage: An overview

The Bill's committee stage began with four sessions of oral evidence on 7 and 9 September 2021, followed by 20 sessions of line-by-line scrutiny on 14, 16, 21 and 23 September, 19, 21, 26, 27 and 28 October, and 2 November 2021.

151 amendments and 70 new clauses were tabled. Amendments 10 to 16, 117 to 121, and 147 to 148, and New Clauses 59 to 62 were all introduced by the Government and subsequently added to the Bill. While many of these Government amendments made technical changes, the new clauses have the following effect:

- impose a duty on the Care Quality Commission (CQC) to carry out reviews and assessments into the overall provision of NHS care and adult social care services within the area of each ICS Integrated Care Board (New Clause 59);
- create a new power for the Secretary of State to intervene where local authorities are failing in the exercise of functions under Part 1 of the Care Act 2014 (adult social care) and make consequential amendments (New Clause 60);
- remove the power of the CQC under section 50 of the Health and Social Care Act 2008 to give a notice of failure to an English local authority (New Clause 61); and
- to provide for circumstances where community pharmacies and other dispensing services do not have to be paid to supply medicines because stocks have been centrally purchased by the NHS (community pharmacists and dispensing doctors are usually paid to cover the cost of purchasing the medicines they dispense) (New Clause 62).

Amendments and new clauses were tabled by the Opposition and other members of the committee on a wide range of issues, none of which were accepted. In some cases, the Minister of State, Edward Argar, committed to further consideration of the issues raised. In response to concerns about private sector involvement on ICBs, the Minister committed to bringing forward an amendment on Report to prevent individuals with significant interests in private healthcare from sitting on them.

A record of what happened to each clause, schedule, amendment, and new clause considered at committee stage is set out in a document published on the Bill pages of the Parliament website.[1] Transcripts of the committee stage debates are also available.

[1] Health and Care Bill Committee Stage Decisions, 2 November 2021

2 The Public Bill Committee membership

The Public Bill Committee was chaired by Steve McCabe, Sheryll Murray, Peter Bone and Julie Elliott. It comprised ten Conservative MPs, seven Labour MPs, and one SNP MP. Its membership was as follows:

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

Following the Government reshuffle on 16 September 2021, Jo Churchill and Maggie Throup were replaced on the Committee by Saqib Bhatti (Meriden, Con) and Steve Double (St Austell and Newquay, Con).

3 Evidence sessions

The Bill's committee stage began with four sessions of oral evidence on 7 and 9 September 2021. The Public Bill Committee heard oral evidence from the following organisations:

- NHS Employers,
- Health Education England,
- NHS England and NHS Improvement,
- NHSX
- NHS Providers
- NHS Confederation
- Care Quality Commission,
- Healthcare Safety Investigation Branch,
- Local Government Association,
- Faculty of Public Health,
- Welsh Government,
- UNISON,
- British Medical Association,
- Royal College of General Practitioners,
- Royal College of Nursing,
- Academy of Medical Royal Colleges,
- The King's Fund,
- Nuffield Trust,
- Gloucestershire Integrated Care System, and the NHS Confederation's ICS Network Advisorate,
- Centre for Governance and Scrutiny,
- Centre for Mental Health,
- Healthwatch England,
- Association of Directors of Adult Social Services,
- British Association of Social Workers.

Transcripts of the evidence sessions and the written evidence received by the committee are available on the publications section of the Bill's parliamentary webpage.

4 Detailed consideration of the Bill

4.1 NHS England

Clause 1 of the Bill would formally merge NHS England and NHS Improvement. There are additional provisions to abolish the two statutory bodies which currently make up NHS Improvement and transfer most of their functions to NHS England.[2] Schedule 1 contains consequential amendments which seek to amend other legislation to change any references to the NHS Commissioning Board to NHS England.

Appointment of NHS England board members

Justin Madders introduced **Amendment 18** to change the make-up of the Board of NHS England. He said the amendment would define the composition of the Board to align better with integrated care. He also said NHS England board members:

> ...should be subject to more independent assessment of their value and must pass at least some fit and proper test to avoid obvious conflicts of interest. The amendment would ensure that the key influences on the board come from public health, local government, the patients themselves and the staff, without whom the NHS does not exist.[3]

The Minister of State, Edward Argar, said unlike appointments to Integrated Care Boards, the appointment of the chair and non-executive members of NHS England are public appointments made by the Secretary of State, and these are managed in line with the governance code for public appointments and regulated by the Commissioner for Public Appointments. He said appointments to the board of NHS England:

> ...are made on merit in a fair, open and transparent manner and in line with that governance code. They also require due regard to ensuring they properly reflect the populations they serve, including a balance of skills and backgrounds, supporting the Government agenda of promoting more diverse public sector organisations and board appointments.

The Minister said while he shared the shadow Minister's view that it is "hugely important" to have diverse representation on the board of NHS England and

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2 Since 2016 NHS Improvement has been the operational name for the two different bodies (Monitor and the Trust Development Authority) that support and oversee NHS Trusts and Foundation Trusts, as well as independent providers that provide NHS-funded care.

3 PBC Deb 14 September 2021 c172

to ensure that diverse voices and viewpoints are reflected, the duty under section 13H of the 2006 Act already requires NHS England to actively "promote the involvement of patients, and their carers and representatives" without the specific need for a named non-executive patient representative.[4]

The amendment was withdrawn.

NHS England mandate (Clause 3)

The Health and Social Care Act 2012 established a duty for the Secretary of State to provide a Mandate to NHS England before the beginning of each new financial year, to set its strategic direction.

Clause 3 removes the requirement for a Mandate to be set before the start of each financial year. Instead, the Secretary of State will be able to set a Mandate at any time. The Bill would ensure there is always a Mandate in place which remains in force until replaced by a new Mandate.

Justin Madders introduced **Amendment 19** to specify that, if the Secretary of State revises the mandate, it must be published and laid before Parliament with a written justification for the urgent or unforeseen circumstances behind the revision, together with an impact assessment. This was discussed alongside **Amendment 20**, providing that no mandate may be laid before Parliament unless the Secretary of State has supplied a statement on how it will be funded.[5]

Mr Madders asked the Minister to reflect on two matters raised in the amendments:

> First, a change to a mandate during its natural term could be hugely disruptive, so there should be some requirement, as set out in our amendment, for the Secretary of State to do that only in urgent circumstances, and to show Parliament that the need to change the mandate outweighed the destruction and costs of doing so. The last 18 months demonstrate what urgent circumstances look like, but we would not want to try to list them, because no one can predict the future.
>
> Secondly, any mandate without a proper financial analysis will always be open to question. The setting of the mandate must be tightly linked to the allocation of funding, not entirely divorced from it, as it appears to be.[6]

Edward Argar described the intention of Clause 3 as drafted:

> ...to increase [the mandates] effectiveness as a long-term strategic tool, framed in a way that can endure rather than having an annual use-by date. (...)

4 PBC Deb 14 September 2021 c176
5 PBC Deb 14 September 2021 c184-5
6 PBC Deb 14 September 2021 c186

> The priorities naturally evolve, based on the Government's collaborative discussions with the NHS and wider Government, as well as insights on where the NHS should focus its resources from patients, the public and their representative groups, and of course staff.[7]

He said Amendment 19 would "…potentially prevent such flexibility and democratic adjustment, save in response to urgent or unforeseen circumstances."[8]

The Minister argued the additional requirement for an impact assessment on mandate revisions which Amendment 19 would require was unnecessary, as Clause 21 provides for financial directions to be laid in Parliament in the future. He said the new duty for the Secretary of State to lay financial directions in Parliament "…will ensure that Parliament is given a regular assurance on the funding that is being provided to support the delivery of the mandate objectives in the financial year ahead."[9] Amendment 19 was rejected following a vote.

4.2 Responsibility for the NHS in England

Justin Madders moved **Amendment 36**, in Clause 2. This, along with **Amendment 37**, and **New Clauses 20** and **21**, would have restored the wording of section 1 of the NHS Act 2006 to its original form before amendment by section 1 of the Health and Social Care Act 2012.

Currently, section 1 of the 2006 Act, as amended by the 2012 Act, sets out the Secretary of State's duty to promote "a comprehensive health service".

Section 1 of the 2012 Act substituted the duty under sub-section (2) of the 2006 Act "to provide or secure the provision of services in accordance with this Act" with a duty for the Secretary of State to "exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act". The duty under sub-section (2) inserted by the 2012 Act no longer refers to a duty to provide.

During the passage of the 2012 Act the Government explained the reason for removing the Secretary of State's duty to provide from section 1 of the NHS Act 2006. At the time, Ministers said this reflected the fact that, even under the pre-2012 system, the duty did not reflect the reality of commissioning and provision arrangements which rest with NHS bodies and not the Secretary of State. It was argued the duty would become more anachronistic once

7 PBC Deb 14 September 2021 c189-90
8 Ibid
9 PBC Deb 14 September 2021 c190

responsibility for commissioning and providing services passed to NHS England and clinical commissioning groups (CGCs).[10]

Concerns were raised in debates on the 2010-12 Bill about the removal of "provide" from the Secretary of State's duties. In response, the Government agreed to support amendments proposed by the House of Lords Constitution Committee during the final stages of the Health and Social Care Bill 2010-12 to insert a new paragraph in Clause 1, to clarify that the Secretary of State retains Ministerial accountability for the NHS.[11]

Mr Madders referred to debates on the Secretary of State's overall responsibility for the NHS which took place during the passage of the Health and Social Care Bill 2010-12 (which he referred to as the "Lansley Bill", after the then Secretary of State for Health, Andrew Lansley). He said:

> The contentious bit of this issue is really about what makes up the NHS. It was claimed about the Lansley Bill, and has been claimed about this Bill, that the change in wording implies that people would be denied access to treatment from the NHS because, for example, an ICB decides to exclude a particular service, and there is no duty on the Secretary of State to stop that happening.[12]

The shadow Minister provided some further rationale for the Opposition amendment, which was intended to make the Secretary of State's duties clear with a move away from the 2012 Act structure:

> Under the current Bill, the ICBs have a responsibility to provide services for a defined population that is phrased much like the above definition, but there is no duty on the Secretary of State to provide throughout England; in other words, there is nothing specific to say that the duty on the Secretary of State should be delegated to ICBs, which we say there should be. Our intention is to restore the position that the duty is placed on the Secretary of State, which he then delegates down to NHS England, ICBs and so on. (…)
>
> The Lansley changes were made to align with the NHS structures that the then Secretary of State introduced, which were essentially market structures, distancing the Secretary of State in the sense that they were unlike anything the NHS had done previously, which was part of the reason why there was so much debate about them. That is why in 2015, 2017 and 2019, we made it clear in my party's manifesto that we would reinstate the duty to promote and deliver the NHS, so there would be no doubt that it was a public service and could be restored to that footing. (…)

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10 Wider debate on the decision to remove "provide" from section 1 of the 2006 Act can be found in pages 8-10 of the Library Research Paper on the Health and Social Care Bill (RP 11/63, 30 August 2011).

11 HL Deb 8 February 2012 cc298-307

12 PBC Deb 14 September 2021 c180

> Let us keep it simple, save everyone a lot of work and go back to the old wording, so that there is no doubt about where the duties and responsibilities lie.[13]

Edward Argar also referred to debates on the wording of the Secretary of State's responsibilities for the NHS during the passage of the 2012 Act. He noted that the Lords had concluded it was better for the law to reflect the reality of the modern NHS. However, he said:

> ...it remains the case that the Secretary of State has a firm duty to continue the promotion in England of a comprehensive health service in practice. He does this through setting the strategic direction and his oversight of NHS England and the other national bodies of the NHS, and in the future, subject to debates in this place—I do not want to prejudge what the Committee and the House may determine on those clauses—through the extra lever of the proposed power of direction. At all times, he remains responsible to Parliament for the provision of the health service in England.[14]

The Minister also said NHS England has a duty to arrange for the provision of services for the purpose of the health service in England and a concurrent duty to promote a comprehensive health service. He said integrated care boards will, subject to parliamentary approval of the Bill, also have functions in relation to arranging the provision of services. The Minister said he suspected the debate in Committee would return to the extent to which the legislation should be prescriptive, or permissive and flexible. The Labour frontbench withdrew the amendment.[15]

4.3 The NHS triple aim

The 2019 NHS Long Term Plan proposed a 'triple aim' for the NHS of better health and wellbeing, better quality health care and ensuring financial sustainability. The February 2021 White Paper committed to creating a shared duty on all NHS bodies to pursue this triple aim. Clause 4 requires NHS England to have regard to the 'triple aim' duty, which will also apply to Integrated Care Boards (under Clause 19), NHS trusts (Clause 43) and NHS Foundation Trusts (Clause 56).

Shadow Minister Alex Norris introduced a group of amendments (**Amendments 21-26**) that would have modified the triple aim to take account of health inequalities and make population health and wellbeing the primary consideration in NHS decision making:

13 PBC 14 September 2021 c181
14 PBC 14 September 2021 c183
15 PBC 14 September 2021 c184

- **Amendment 21** would modify the triple aim to explicitly require NHS England to take account of health inequalities when making decisions.
- **Amendment 22** would assert that the health and well-being of the people must be the primary consideration of NHS England, when making decisions about the exercise of its functions.

Amendments 23 to **26** were aimed at making the same modification to the aims of ICS Integrated Care Boards, and to NHS Trusts.

The shadow Minister also introduced **New Clause 13**, that would have required the Secretary of State to set and report on targets for the improvement of the physical and mental health of the population, and the reduction of health inequalities, at least every five years.[16]

Mr Norris described the three strands of that triple aim as "noble" but "…not robust enough to ensure not just due regard for health inequalities but strong action." He said accepting Amendment 21 would:

> …send a signal to NHS England that tackling health inequalities ought to be at the centre of its mission. A quadruple aim may not be as elegant as a triple aim, but it is important that tackling health inequalities is recognised in the Bill.[17]

Turning to New Clause 13, Mr Norris said in order to get serious about health inequalities they need to be better understood, and for that to happen "the Government of the day need to be more accountable for them."[18]

Responding, Edward Argar said this Amendment could make it more difficult to swiftly focus on ensuring inequalities are identified and acted on:

> Had we a fixed, five yearly set of targets to work towards, I fear that it would introduce more rigidity, rather than the agility and flexibility that we seek in meeting the changing assessments of what underlying health inequalities must be tackled as a priority.[19]

Mr Argar argued amendments to add a "fourth limb" of tackling health inequalities to the triple aim for NHS England, ICBs and NHS trusts, were unnecessary. He said there are existing statutory duties on bodies in this area, many of which relate specifically to health inequalities. He added NHS England will have to consider such duties when it produces guidance on the triple aim.[20]

16 PBC Deb 14 September 2021 c193
17 PBC Deb 14 September 2021 c195
18 PBC Deb 14 September 2021 c197
19 PBC Deb 14 September 2021 c200-1
20 PBC Deb 14 September 2021 c201

4.4 Integrated Care Systems

CQC reviews of Integrated Care Systems (New Clause 59)

In considering their White Paper proposals for the Bill the Health and Social Care Committee recommended the Government introduce provisions to enable the Care Quality Commission (CQC) to undertake ratings of Integrated Care Systems. They further recommended the CQC's assessment of ICSs should include consultation with patient groups and consideration of patient outcomes.[21] On 6 July 2021, the new Secretary of State, Sajid Javid, sent a letter to the Health and Social Care Committee (344KB, PDF) confirming new powers for the CQC to assess ICSs would be introduced as an amendment to the Bill.[22]

In Committee the Government introduced **Amendments 147** and **148,** and **New Clause 59**, to impose a duty on the CQC to carry out reviews and assessments of overall provision of NHS care and adult social care services within the area of each ICS Integrated Care Board. The Amendments and New Clause were agreed and added to the Bill.

Amendment 147 would give the CQC a duty to review integrated care systems. The Minister set out what this would allow the CQC to do:

> It will allow the CQC to look broadly across the system to review how integrated care boards, local authorities and providers of health, public health and adult social care services are working together to deliver safe, high-quality and integrated care to the public. That will include the role of the integrated care partnership. The experience of, and outcomes for, people who use health and care services will be central to the reviews, especially when people experience gaps between services that impact on their health and care outcomes. The work will provide valuable information to the public on the quality of health and care in their area and will review progress against our aspirations for delivering better, more joined-up care across the system.[23]

The Minister said the amendments would require the CQC to publish a report on each ICS area to ensure the public has access to information about the provision of care in their area. He also set out what the expected focus of the reviews would be, at least initially:

> The reviews will focus on how well integrated care boards, local authorities, NHS providers and other system partners, such as those in

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21 See Health and Social Care Committee, The Government's White Paper proposals for the reform of Health and Social Care, 14 May 2021, HC 20 2021-22, para 24, pages 7-8

22 DHSC, Letter from Rt Hon Sajid Javid MP to Members of the Health and Social Care Committee, 6 July 2021

23 PBC Deb 26 October 2021 cc643-649

> voluntary, community and social enterprise sectors, are working together to arrange and deliver integrated services, including the role of the integrated care partnership. We expect the initial focus of the reviews to be on leadership, integration, and quality and safety, with flexibility for the Secretary of State to set the strategic direction of these reviews by setting the objectives and priorities.[24]

Mr Norris said he was glad to see this change added to the Bill. He noted the Opposition had been calling for greater oversight of Integrated Care Systems since the publication of the White Paper. He said Labour had offered options in previous sittings around democratic accountability, which is their preference. He acknowledged the change represented progress.[25]

ICS boundaries

Justin Madders moved Amendment 49, in Clause 13, which provides for the establishment of Integrated Care Systems (ICSs). This amendment would have ensured consultation of trusts and local authorities before changes to ICS' boundaries.

Mr Madders noted concerns that the current boundaries of the 42 ICS had been imposed by the NHS with little input from local government, and this was a great weakness in the whole Bill. He said the Opposition amendment would seek greater consultation with trade unions, local authorities, and NHS trusts over any future changes to ICS boundaries:

> It is supposed to be about integration between local authorities and the NHS, but it is almost all about what the NHS wants and what it thinks is the best outcome. It should have been co-produced with local government, not presented as a fait accompli. (…) Amendment 49 seeks that, in future, any changes in ICS boundaries should be decided in consultation and conjunction with trade unions, local authorities and trusts, and that they are consulted before any further changes to the shape or size of ICSs are made.[26]

Karin Smyth and Edward Timpson also raised concerns about ICS boundaries in their respective areas.

Edward Argar, said the amendment was unnecessary because under Clause 13, proposed new section 14Z25, NHS England is already required to consult any ICS Integrated Care Board (ICB) that is likely to be affected before varying or revoking an ICB's establishment order. He said given ICBs will have members from different NHS trusts and local authorities, they would be the best-placed bodies to bring those views together and to reflect opinion on what is an appropriate boundary or establishment area.

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24 Ibid

25 PBC Deb 26 October 2021 c651

26 PBC Deb 14 September 2021 c217

He said Section 13Q of the NHS Act 2006 already places a duty on NHS England to involve and consult the public in planning commissioning arrangements, including in respect of any planned changes. He drew the Committee's attention to the requirement in Clause 13, proposed new section 14Z26, for CCGs to consult any person they consider as appropriate on the first ICB constitution.[27]

Responding to the Minister, Justin Madders outlined why he was not reassured by the existing consultation duties:

> The Minister referred to proposed new sections 14Z25 and 26 in regard to the duties to consult with members of the ICB. Some of the people named in amendment 49 might not actually be on the ICB, because they are not included in the legislation at the moment. We will come to our amendment on that in due course, and we might be able to change that. In proposed new sections 14Z26, CCGs must
>
> "consult any persons they consider it appropriate to consult".
>
> That could be everyone and no one.[28]

He said he did not intend to press the amendment to a vote but hoped the Minister had taken on board several points which would result in an improved process in future.[29]

Transfer of property, rights, and liabilities to Integrated Care Boards

The Minister introduced **Amendment 10**, which he said was a technical amendment to add a power for NHS England to transfer property, rights and liabilities (including rights and liabilities relating to a contract of employment) from certain NHS bodies to an Integrated Care Board (ICB) on its establishment. This was debated alongside Government **Amendment 11**, a further technical and consequential change to transfer arrangements.

The Minister explained that, as originally drafted, the Bill (via proposed new section 14Z28) only provided NHS England with the power to transfer property, rights, and liabilities between Clinical Commissioning Groups (CCGs), which would be abolished, and ICBs. Amendment 10 would widen the power to include transfers to ICBs from NHS England, English NHS trusts or foundation trusts, or English special health authorities.

He assured the Committee these amendments would not affect NHS England's employment commitment to continuity of terms and conditions of transferring staff.

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27 PBC Deb 14 September 2021 c223-4

28 PBC Deb 14 September 2021 c228

29 Ibid

The Minister said it would be "possible for NHS England to use the schemes to transfer property and liabilities currently held by those bodies to ICBs on their establishment," although he said he would "expect that to be rare in practice."[30]

Both amendments were agreed without division.[31]

Reporting duties on Integrated Care Boards and the Secretary of State

Justin Madders moved **Amendment 38** to Clause 13, to place new requirements on Integrated Care Boards (ICBs) to report annually directly to the Secretary of State on their actions, and on the Secretary of State to prepare and publish an annual report for Parliament specifically on the actions of the ICBs. It would have required a Minister of the Crown to propose a motion in the House of Commons in relation to the report no later than one month following it being laid in Parliament.

Edward Argar agreed there should be strong lines of democratic accountability from ICBs to Parliament. He hoped to reassure the shadow Minister that the Bill already provided for much of the transparency and accountability he was seeking. In particular, he noted the Bill already contained two relevant reporting duties:

> Proposed new section 14Z26 of the National Health Service Act 2006 already places a duty on ICBs to prepare an annual report explaining how the ICB has discharged its duties, particularly in relation to its activities to improve the quality of services, reduce health inequalities and have regard to the effect of its decisions on, and its involvement with, the public.
>
> I hope the Committee will agree that that is already a comprehensive reporting requirement. Further, under proposed new section 14Z57, NHS England is also required to undertake annual performance assessments to review how each individual ICB has discharged its functions, including how it has delivered on its statutory duties. The Secretary of State will have the power to issue statutory guidance concerning performance assessments, meaning that national Government will be able to influence the methods and requirements of assessment if necessary. Again, NHS England must publish the results of each performance assessment, meaning that the public will have open access to information concerning the performance of their ICBs.[32]

The amendment was withdrawn.

30 PBC Deb 14 September 2021 c229
31 Ibid
32 PBC Deb 14 September 2021 c232

Appointment of Integrated Care Board leadership

Justin Madders introduced a group of amendments relating to the appointment of ICS Integrated Care Board (ICB) chairs and chief executives:

- **Amendment 31** to provide for ICBs to have a locally elected chair after a period of no more than 2 years (with the first Chair of each Integrated Care Board to be appointed by NHS England, with the approval of the Secretary of State).
- **Amendment 50** to remove the Secretary of State's role in approving the appointment of ICB chairs.
- **Amendment 51** related to consultation on an ICB chair's appointment, and would have mandated NHS England to consult with the ICB before appointing a chair.
- **Amendment 52** related to ICB and Integrated Care Partnership (ICP) members' involvement in the ICB chief executive's appointment, and would have required the chair to consult with both the ICB and ICP before appointing a chief executive.

The shadow Minister said he would press Amendment 31 to a vote, as he believed "a focal point of local accountability is vital." He said when something goes wrong, or decisions are made that people are unhappy about, they "…need someone they can hold to account at the ballot box."[33]

Amendments 31 and 50 were both negatived on division.

Membership of Integrated Care Boards (Schedule 2)

Schedule 2 sets out the minimum membership of Integrated Care Boards (ICBs): the chair and the chief executive; one member to represent NHS trusts; one person to represent primary care; and one person to represent all the local authorities in the area.

Alex Norris moved **Amendment 32**, to Schedule 2, to require ICBs to have members nominated by Directors of Public Health, mental health trusts, social care providers and trade union representatives, and a member representing patients. Dr Philippa Whitford spoke in support of the amendment, which she described as probably one of the most important amendments so far.

> In the witness discussion, we came back time and again to which voices would be on the ICB and would be able to influence. I agree that, with all the talk of parity of esteem, it seems incredible that there would not be a voice representing the importance of mental health on the board. Similarly, with the talk of moving to population health and wellbeing, there is a need for directors of public health to agree policy and to feed in information about the underlying health inequalities, life expectancy and so on in the local population. Not to have a social care voice when what

[33] PBC Deb 14 September 2021 c244

> the Government say is that they are trying to integrate the NHS with social care seems quite bizarre.[34]

Edward Argar said Schedule 2 sets out minimum membership of the ICB but this is "very much de minimis—it is not what will happen; it is the baseline, above which each system can go if it wishes to reflect local needs and priorities."[35] He went on to say that the minimum membership requirement could be expanded through regulations if needed at some point in the future:

> If in time, when those ICBs are up and running, it becomes clear that that approach needs strengthening and that we need to add further requirements, regulation-making powers in schedule 2 will allow the Secretary of State to do so at a later point. We believe that it is right to start at this de minimis point in the Bill. It reflects our view, which I have articulated throughout, that we must not attempt to over-legislate at this stage on the composition of ICBs, letting them evolve as effective local entities, to reflect local needs. It may not fully reassure the hon. Gentleman, but there is a mechanism whereby further changes could be made in future, although we do not believe that will be necessary.[36]

Amendment 32 was rejected following a vote.

Alex Norris then introduced a group of amendments attempting to prohibit representatives of private providers of healthcare becoming ICB members.[37] He moved **Amendment 30**, in Schedule 2, to prohibit representatives of GP practices with active Alternative Provider Medical Services (APMS) contracts from becoming members. This amendment would have meant the only GPs able to participate in ICBs would be those whose practices are on the standard General Medical Services (GMS) contract. In contrast to GMS, the APMS contract can be held by private companies as well as traditional GP partnerships. This amendment was debated with **Amendment 33**, in schedule 2, to prevent private providers of healthcare services from becoming members of ICBs, and **Amendment 27**, in Clause 20, to prevent private providers of healthcare services from becoming members of Integrated Care Partnerships.

Addressing Amendment 30, the Minister noted that APMS contractors include some private and third-sector organisations, but also some GP partnerships. These contractors include, for example, social enterprises and partnerships providing services to homeless people and asylum seekers.[38]

The Minister said he appreciated the intention of the amendments, namely the desire to avoid the appearance, and potentially even the risk, of privatisation and conflicts of interest. However, he said the effect would be to

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34 PBC Deb 14 September 2021 c250

35 Ibid

36 PBC Deb 14 September 2021 cc250-1

37 PBC Deb 14 September 2021 c253

38 PBC Deb 14 September 2021 c258

limit the ability of primary medical service providers to appoint an ICB member who might best meet the requirements of the local population.[39]

Turning to Amendments 33 and 27 the Minister said he recognised the involvement of the private sector, in all its forms, in ICBs was a matter of significant concern to Members in the House, and said "we are keen to put the point beyond doubt". Noting some potential drafting issues with the Opposition amendments, the Minister proposed to bring forward a Government amendment on Report "…to protect the independence of ICBs by preventing individuals with significant interests in private healthcare from sitting on them."[40] He set out the Government's approach to private sector involvement in ICBs and ICPs. With regard to ICBs he said:

> It is by no means our intention to allow private sector providers to influence, or to make, decisions on spending on the commissioning board—the ICB—and the spending of public money.[41]

The Minister noted that the decision to create ICPs came from discussions with a number of stakeholders who made a strong case for the creation of a committee to consider strategically not only the health needs, but the broader social care and public health needs of a population:

> We therefore do not intend to specify membership for the ICP in the Bill, as we want local areas to be able to appoint members as they think appropriate. To support that, we have recently been working with NHS England and the Local Government Association to publish an ICP engagement document setting out the role of integrated care partnerships and supporting local authorities, integrated care boards and other key stakeholders to consider what arrangements might work best in their areas.
>
> We would expect members of the ICP to be drawn from a very wide variety of sources and backgrounds, including the health and wellbeing boards within the system; partner organisations with an interest in health and care, such as Healthwatch; and potentially voluntary and independent sector partners and social care providers at that level, as well as organisations with wider interests in local priorities, such as housing providers.[42]

Given the Minister's offer to bring forth a Government amendment on Report, the Labour frontbench withdrew Amendment 30 and did not move Amendment 33 (Amendment 27 was not called).

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39 Ibid

40 Ibid

41 Ibid

42 PBC Deb 14 September 2021 c258-9

The constitution of Integrated Care Boards (Schedule 2)

Justin Madders moved **Amendment 48**, in Schedule 2 (which concerns the constitutions of Integrated Care Boards), that would have required Integrated Care Boards (ICBs) to be clear about how they would make changes in clinical policies and established models of care put in place by CCGs in the area for which the ICB takes responsibility.[43]

The shadow Minister noted most ICBs will take responsibility for populations and areas covered by a number of different CCGs, which may have different policies on availability of services and on patient access eligibility criteria. He asked how these different CCG policies would be merged into a single ICB policy in areas such as fertility treatment, where there was variation in access. The Minister again noted that Clause 19 of the Bill already places a duty on ICBs to involve and consult the public on commissioning arrangements planning, including on any proposed changes. He confirmed this would include, for example, plans by an ICB to change the range of health services available to the public or the manner in which they are delivered. The amendment was withdrawn.[44]

Alex Norris moved **Amendment 34** that would have mandated ICBs and their sub-committees, including "place based committees" to meet in public and publish all papers and agendas at least five working days before each meeting. Edward Argar set out what is already specified under the Public Bodies (Admission to Meetings) Act 1960, which places a set of requirements to involve the public in meetings very similar to those in the amendment. He said ICBs have already been included in the scope of the 1960 Act by consequential amendments in Schedule 4 to the Bill.[45] The amendment was withdrawn.

Justin Madders moved **Amendment 43** to Schedule 2. This amendment would have put into primary legislation the current practice of NHS bodies honouring collective agreements over staff pay and conditions, and would have given the ICB a role in ensuring this remains the case.

This amendment reflected concerns raised in Unison's written and oral evidence to the Committee on the future of national collective agreements, such as the Agenda for Change deal. The Minister offered to write to the shadow Minister to reassure him of the Government's and the NHS's commitment to the principle of "Agenda for Change". The Minister also confirmed staff transferring into ICBs will transfer across on their current terms and conditions with reserved rights to their NHS pensions.[46] The amendment was rejected following a vote.

Karin Smyth moved **Amendment 17** to Schedule 2 which she described as a probing amendment. It would have enabled ICBs to participate in existing and

43 PBC Deb 14 September 2021 c234
44 PBC Deb 14 September 2021 c235-6
45 PBC Deb 16 September 2021 c268
46 PBC Deb 16 September 2021 c274

future externally funded development agreements, known as Local Improvement Finance Trust (LIFT) schemes. These schemes are a form of public private partnership that can be used to build and refurbish primary care premises which are leased to GPs. The Minister said he believed the ability to enter into an externally funded development agreement was already covered by provisions in paragraph 20 of schedule 2. The amendment was withdrawn following debate.

There was a stand part debate on Clause 14 and Schedule 2.

Integrated Care Board duties and powers to commission health services (Clauses 15 and 16)

Clause 15 provides Integrated Care Boards (ICBs) with duties and powers to commission hospital and other health services for those persons for whom they are responsible. Clause 16 gives ICBs responsibility for medical, dental and ophthalmic primary care functions.

Edward Argar moved Government **Amendment 12**, to specify that Integrated Care Boards (ICBs) have a duty to commission secondary medical services (replicating the current position for Clinical Commissioning Groups). Although secondary medical services would appear to fall within new section 3(1)(f) and (g), in the existing legislation they are mentioned specifically so the amendment would continue that approach.[47]

This amendment was discussed alongside Government Amendment 13, to make it clear ICBs have a duty to commission secondary ophthalmic services (replicating the current position for clinical commissioning groups). Again, although secondary ophthalmic services would appear to fall within new section 3(1)(f) and (g), in the existing legislation they are mentioned specifically so the amendment would continue that approach.

Mr Argar described both amendments as technical changes to clarify the commissioning responsibilities of ICBs. The shadow Minister, Justin Madders, said Labour would not oppose the amendments or clause 15. He agreed it was important to make it very clear that ICBs could not unilaterally withdraw certain services, a concern which had been raised."[48]

During the stand part debate for Clause 16, two Opposition amendments to Schedule 3 were discussed (Amendments 28 and 29). These would have prevented an ICB or NHS England from entering into or renewing any GP contract other than with an individual general practitioner, GP partnership or social enterprise. The Minister said the aim of the Opposition amendments appeared to be to exclude the NHS from entering into Alternative Provider Medical Services (APMS) GP contracts. He said advice on the amendments indicated they would bar some limited companies from holding general and

47 PBC Deb 16 September 2021 c289

48 PBC Deb 16 September 2021 cc289-90

personal medical services contracts "which would have a potentially devastating effect on primary care."[49]

Amendment 28 was negatived on division.

Duties of Integrated Care Boards (Clause 19)

Clause 19 sets out a number of duties that Integrated Care Boards (ICBs) will be subject to in carrying out their responsibilities. These are similar to some of the duties placed on NHS England and Clinical Commissioning Groups under the Health and Care Act 2012. While 15 amendments were tabled to this clause, only 4 were moved (**Amendments 7, 45-46** and **58**).

Justin Madders moved **Amendment 45**, to place a duty on each ICB, in the exercise of its functions, to meet maximum waiting time standards as set out in the NHS constitution. The amendment was rejected following a vote.[50] The other 3 amendments to Clause 19 were withdrawn after debate and covered the following areas:

- **Amendment 7**, introduced by Chris Skidmore, to require ICBs to work with universities to support research in their local health and care systems. This was discussed alongside Amendment 8, to require ICBs to work with universities and other education providers to promote education and training in their local health and care systems.
- Opposition **Amendment 46** to place a requirement on ICBs to share information with the Domestic Abuse Commissioner at their request.
- Opposition **Amendment 58**, to mandate ICBs to work with the life science sector, facilitated by Academic Health Science Networks (AHSNs), to promote innovation in health services.

Edward Argar said Clause 19 inserts 31 new sections, relating to the functions and duties of ICBs, into the NHS Act 2006. He described the clause as the cornerstone of the ICB provisions. He said, given the importance of these provisions in the Bill, he would take Members through them during the stand part debate.[51]

Integrated Care Partnerships (Clause 20)

Clause 20 would require Integrated Care Boards (ICBs) and relevant local authorities to establish a statutory joint committee for the ICS – known as Integrated Care Partnerships (ICPs) – which will bring together health, social care, public health, and wider partners.

Justin Madders introduced **Amendment 47**, that would have required the Secretary of State to establish a procedure for the resolution of any dispute

49 PBC Deb 16 September 2021 c293
50 PBC Deb 16 September 2021 c303
51 PBC Deb 16 September 2021 c314

between an ICP and an ICB on implementation of a strategy produced by the ICP. This amendment was rejected following a vote.[52]

Dr James Davies moved **Amendment 55**, to require ICPs to consider representation from the full spectrum of services used by babies, children, and young people, including education settings. This was discussed alongside **Amendment 54**, to require an ICP to specifically consider the needs of babies, children and young people when developing its strategy. Amendment 55 was withdrawn after debate.[53]

Financial responsibilities of Integrated Care Boards and their partners (Clause 23)

During the stand part debate on Clause 23, Justin Madders moved **Amendment 53**, to introduce an objection mechanism when an Integrated Care Board (ICB), NHS trust or foundation trust believes its capital resource limit or revenue resource limit risks compromising patient safety. Specifically, NHS England would have been required to publish guidance on the means by which an ICB, NHS trust or NHS foundation trust could do this. The amendment was withdrawn after debate.[54]

4.5 Workforce plans (Clause 33)

Clause 33 places a duty on the Secretary of State to publish, at least once every five years, a report describing the system for assessing and meeting the workforce needs of the health service in England.

Chris Skidmore introduced **Amendment 94**, that would have required published assessments every two years of current and future workforce numbers required to deliver care to the population in England. These assessments would be based on economic projections made by the Office for Budget Responsibility, projected demographic changes, the prevalence of different health conditions, and likely impact of technology. This amendment was discussed alongside the following Opposition amendments:

- **Amendment 2**, that would have required the Secretary of State to publish a report on assessing and meeting the workforce need annually.
- **Amendment 40**, that would have required the Secretary of State to publish a report on assessing and meeting the workforce need for both health and social care services.
- **Amendment 41**, that would have required Health Education England to publish a report each year on projected workforce shortages and future staffing requirements for health and social care services in the following

52 PBC Deb 16 September 2021 cc325-31
53 PBC Deb 16 September 2021 cc322-5
54 PBC Deb 16 September 2021 cc338-42

five, ten and twenty years. The amendment set out a number of specific requirements for the report.
- **Amendment 42** that would have required the annual workforce report to include an assessment by the Secretary of State of safe staffing levels in the health service in England and whether those levels are being met.

Amendment 94 was withdrawn after debate, while Opposition Amendments 40 and 41 were negatived on division.[55]

Plaid Cymru MP Hywel Williams moved **Amendment 85**, to require the Secretary of State for Health and Social Care to consult the Welsh Government before the functions on workforce assessments in this clause are exercised. This amendment was withdrawn after debate.[56]

4.6 Reconfiguration of NHS services: intervention powers (Clause 38)

Clause 38 inserts Schedule 6 which gives the Secretary of State power to give a direction to the NHS calling in any proposal for a local NHS service reconfiguration. The Schedule allows the Secretary of State to take on the decision-making role of the relevant NHS body with regard to the proposed service change.

During the clause stand part debate on Clause 38 the Committee discussed **Amendments 102** and **103** to Schedule 6, tabled by the Labour frontbench. These amendments would have required the Secretary of State to consult any relevant Health Overview and Scrutiny Committee (as defined by Amendment 102), and to have regard to and publish clinical advice from the Integrated Care Board Medical Director, before intervening in a local service reconfiguration. The Committee also discussed **Amendment 104** to Schedule 6, which would have required the Secretary of State to publish a statement demonstrating that any decision they have made on a reconfiguration proposal is in the public interest.[57]

Talking to Amendments 102-104, Justin Madders said the Opposition did not think Clause 38 would survive the parliamentary process in its current form. He referred to views expressed by witnesses during the Committee's evidence sessions saying the powers in Clause 38 and Schedule 6 were not needed and would not be helpful to the Secretary of State.[58]

Edward Argar set out the Government's rationale for the new intervention power:

55 PBC Deb 21 September 2021 cc373-4
56 PBC Deb 21 September 2021 cc374-8
57 PBC Deb 21 September 2021 c396
58 PBC Deb 21 September 2021 c399

> We believe that the Secretary of State should be able to intervene in reconfigurations for which they are ultimately accountable, and that this proposal will increase accountability to Parliament and the community by enabling intervention at an earlier stage. Too often, controversial proposals are referred at the very end of the process after a huge amount of work, effort and expenditure, rather than at an earlier stage when there is already a divergence of opinion in the local community.[59]

The amendments were not voted on and Clause 38 and Schedule 6 were agreed to on division.

4.7 NHS Payment scheme

Clause 66 of the Bill inserts Schedule 10 and replaces the NHS national tariff with a new NHS payment scheme, and makes further provisions relating to the new system. The Explanatory Notes to the Bill say these measures are designed to give the NHS more flexibility in how tariff prices and rules are set and to help support the delivery of more integrated care at local levels.[60]

Alex Norris introduced **Amendment 84**, to Schedule 10, which would have aimed to ensure payment to private providers could only be made at tariff price, to prevent competition for services based on price. This amendment was discussed alongside **Amendment 100**, which would have required NHS England to obtain the agreement of the Secretary of State before publishing the NHS payment scheme.[61]

The Minister argued against Amendment 84, noting where it may be necessary to differentiate the price paid to different types of provider, while promising not to introduce "competition on price, rather than quality":

> ...there may be scenarios where it is appropriate to pay non-NHS providers different prices from those paid to NHS providers, to take account of differences in the cost of providing those services—for example, different staffing costs or a different range of services provided. There may also be cases where the financial regimes of different providers make it appropriate to set different prices or pricing rules. When setting any prices, NHS England will aim to ensure that the prices payable represent a fair level of pay for the providers of those services, as well as fair pay between providers of similar services. I reassure the Committee that we do not expect to see the rules being used to give a premium to private providers to encourage them to enter the market.[62]

Supporting the amendment, Karin Smyth, highlighted the importance of the NHS payment scheme in allocating a very large proportion of the NHS

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59 PBC Deb 21 September 2021 c411

60 Explanatory Notes the Health and Care Bill 2021-22, para 26

61 PBC Deb 23 September 2021 c451

62 Ibid

budget, and noted concern that the Committee had no idea when the detail of the new system would be available.[63]

The Minister said he expected this to be published "…in the course of 2022." He also referred to **Amendment 107**, which was not selected but which he said highlighted "…issues that we need to put on the record." [64]

This amendment would have required all relevant trade unions and other organisations representing staff working in the health and care sectors to be consulted about the payment scheme. The Minister said NHS staff pay and conditions are outside the scope of the proposed payment scheme and "…are protected by provisions made elsewhere…". He said the Bill already requires NHS England to consult with Integrated Care Boards, relevant providers and any other person the NHS thinks appropriate, before publishing a payment scheme. He added, it must also publish an impact assessment of the proposed scheme.[65]

Amendment 84 was rejected following a vote.

4.8 Patient choice (Clause 67)

Clause 67 requires regulations to be made about how NHS England and ICBs will allow patients to make choices about their care. Clause 67 and Schedule 11 provide for NHS England to take on powers to make guidance, and to resolve breaches of patient choice rules which are currently exercised by NHS Improvement.

During the stand part debate on Clause 67 Karin Smyth moved **Amendment 93**, to extend the scope of the regulations to include patient choice about end-of-life care. She said she would not push her amendment to a vote, but wanted to highlight the issue, and sought responses from the Minister.[66] The Amendment was withdrawn.

4.9 Procurement and provider selection (Clauses 68, 69, Schedule 12)

The Explanatory Notes to the Bill describe the procurement reforms in Clauses 68, 69 and Schedule 12 of the Bill which will enable the removal of the current rules which apply to NHS and public health service commissioners when arranging clinical healthcare services, eg, hospital or community services.

63 PBC Deb 23 September 2021 c460
64 Ibid
65 PBC Deb 23 September 2021 c453
66 PBC Deb 23 September 2021 c465

The Bill provides a power to create a separate procurement regime for these services. This will include removing the procurement of health care services for the purposes of the health service from the scope of the Public Contracts Regulations 2015.

Justin Madders introduced **Amendments 96** and **99** and **New Clause 12**, to ensure that the NHS is the 'preferred provider' when NHS England or Integrated Care Boards (ICBs) commission health services.[67]

New Clause 12 would have established NHS suppliers of services as the preferred providers of NHS contracts, with independent sector providers able to hold NHS contracts only after winning a competitive tender.

Amendment 96 set out what the Opposition considered an "essential de minimis requirement" for the process. As well as requiring NHS England and each ICB to report each year on the proportion of contracts issued to each different type of provider, the amendment would have required the publication of a plan every three years on how they intend to reduce reliance on private providers. Paragraph (d) of Amendment 96 would further require ICBs to publish information on the awarding of contracts "in full and without any recourse to commercial confidentiality".

The shadow Minister set out at length concerns the Opposition and others had raised about the competition and procurement regime for clinical services introduced by the Health and Social Care Act 2012. The Opposition also highlighted uncertainty about what would replace this process. Karin Smyth asked how the patient and public voice would be empowered in the new system, and about the role of local external scrutiny and accountability.[68]

Edward Argar said Amendments 96 and 99 and New Clause 12 would make statutory NHS providers and general practitioners the preferred provider of NHS-funded services. He outlined how this differed from the Government's approach:

> ...our intention is not quite as rigid as what the hon. Gentleman would wish. As I have said, the vast majority of NHS care has and will continue to be provided by public sector organisations, but successive Governments of all political affiliations have allowed the NHS to commission services from the private and voluntary sector, to improve accessibility and experience for patients, to increase capacity swiftly or to introduce innovation.[69]

He went on to provide some context around NHS England's plans for a new provider selection regime:

> By way of context, the NHS has told us that the current competition and procurement rules are not well suited to the way healthcare is arranged.

67 PBC Deb 23 September 2021 cc470-1

68 PBC Deb 23 September 2021 c479

69 PBC Deb 23 September 2021 c483

> That is why we are creating a new provider selection regime that provides greater flexibility, reduces bureaucracy on commissioners and providers alike, and reduces the need for competitive tendering where it adds limited or no value. I fear that the amendments would start reimposing a degree of that bureaucracy. The absence of competitive tender processes does not mean an absence of open, transparent and robust decision making. Our proposed new regime is designed to allow transparency, scrutiny and due diligence in decision making, but without all the barriers and limitations associated with running full tender exercises.[70]

New Clause 12 and Amendments 96 and 99 were rejected following votes.

The Committee then discussed Opposition **Amendment 97**, which would have required a draft of procurement regulations to be laid before Parliament under the affirmative SI procedure.[71] The amendment was withdrawn after a short debate.[72]

4.10 Health and adult social care information

Clause 79 amends powers to publish information standards under the Health and Social Care Act 2012, including to make these standards mandatory for any person to whom they apply unless there is waiver. Clause 80 relates to the sharing of anonymous health and social care information. This clause introduces a power for relevant health or social care public bodies in England to require the sharing of information, other than personal information, for purposes related to their functions in connection with the provision of health services or adult social care in England.

Edward Argar moved a group of Government amendments to Clause 79 to make clear that information standards may be set for public bodies exercising functions in connection with the provision of any health care service in England, and not simply NHS services. These would also make clear the Secretary of State's power to set information standards extends to information concerning health care other than NHS care (**Amendments 117 to 121**).[73]

Alex Norris moved **Amendment 109** to Clause 80, which aimed to prevent the powers provided by the clause being used to require health and care organisations to provide information they could already be required to provide under other powers. It would have required the Secretary of State to review the possibility of combining the exercise of different legislative powers

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70 PBC Deb 23 September 2021 c484

71 Affirmative procedure is a type of parliamentary procedure that applies to statutory instruments (SIs). An SI laid under the affirmative procedure must be actively approved by both Houses of Parliament. Further information on SI procedure is available on the Parliament website.

72 PBC Deb 23 September 2021 c489

73 PBC Deb 23 September 2021 c507

under which health and care data-sharing programmes are run.[74] The amendment was withdrawn after debate.[75]

Medicine information systems (Clause 85)

Clause 85 amends the Medicines and Medical Devices Act 2021 to enable NHS Digital to collect a range of information about the use of medicines and their effects in the UK, and hold this data in one or more information systems. The Explanatory Notes to the Bill say the Medicines and Healthcare products Regulatory Agency (MHRA) would be able to use the information to establish and maintain comprehensive UK-wide medicines registries to improve post-market surveillance on the use of medicines.[76]

Dr Whitford spoke to a group of amendments (**Amendments 60-67**) relating to a number of issues, including:

- To specify the form of data that would be required for a registry or information system
- To require legislative consent of the devolved governments before powers in the clause are exercised
- To further limit disclosure to third parties[77]

The only amendment to be moved was Amendment 65, to allow specified people and organisations who are required to provide information for a registry or information system to provide information to NHS Digital in pseudonymised form. This amendment was withdrawn after debate.[78]

4.11 Transferring the functions of Arm's Length Bodies

Clauses 86 to 92 of the Bill allow the transfer, by regulations, of functions from one of a list of relevant Non-Departmental Public Bodies (NDPBs) to another. It will enable the Secretary of State, by regulations, to provide for the Secretary of State's functions to be delegated to an NDPB. These powers cannot be used to formally transfer any of the Secretary of State's functions to a NDPB.[79]

The Explanatory Notes say there will be a "full and transparent process" in making regulations to transfer or delegate functions, including a formal consultation before regulations are laid before Parliament. Consultation will involve the affected Arm's Length Bodies (ALBs) and, where relevant, the

74 PBC Deb 19 October 2021 cc511-9
75 PBC Deb 19 October 2021 c519
76 Explanatory Notes the Health and Care Bill 2021-22, paras 200-201
77 PBC Deb 19 October 2021 cc525-36
78 PBC Deb 19 October 2021 c536
79 Explanatory Notes the Health and Care Bill 2021-22, para 107

devolved administrations. The Bill provides these regulations will be subject to approval by the Commons and Lords, under the affirmative SI process.[80]

Clause 86 sets out the following "relevant bodies" to which the Secretary of State's powers to transfer will apply:

- Health Education England
- The Health and Social Care Information Centre (known as NHS Digital)
- The Health Research Authority
- The Human and Embryology Authority.
- The Human Tissue Authority
- NHS England

During the stand part debate on Clause 86, Dr Philippa Whitford moved **Amendment 69** to put a duty on the Secretary of State to consult Scottish Ministers before any regulations are made under this section which affect the functions of Scottish Ministers. The Committee also discussed SNP **Amendments 68** and **70-72**, to require the Secretary of State to obtain legislative consent from the devolved governments before powers in the clause are exercised.[81]

Clause 89 sets out detail about what can be done with these powers, and what can be included in regulations. Edward Argar noted that any consequential amendments to devolved legislation would be largely technical and that there are precedents for consequential amendments to devolved legislation:

> The power to make consequential amendments to devolved legislation provided for by clause 89(6) is entirely limited to matters that are genuinely consequential upon regulations and will be largely technical in nature, such as name changes post transfer. The substantive power is to make the transfer of functions, and the consequential amendments flow directly from that. For the statute to work, those consequential changes should not be subject to consent requirements in their own right.
>
> There are precedents for this type of power to make consequential amendments to devolved legislation in many other Acts, and indeed reciprocal powers for devolved Administrations to make consequential amendments to UK Acts of Parliament.[82]

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80 Affirmative procedure is a type of parliamentary procedure that applies to statutory instruments (SIs). An SI laid under the affirmative procedure must be actively approved by both Houses of Parliament. Further information on SI procedure is available on the Parliament website.

81 PBC Deb 19 October 2021 cc541-2

82 PBC Deb 19 October 2021 c545

Dr Whitford said she did not plan to push the amendment to a vote because the Minister said he was consulting the Scottish and Welsh Cabinet Secretaries.[83]

During the stand part debates on Clauses 86 to 92, relating to the transfer of ALB functions, Alex Norris questioned why they were necessary and argued there was no clear rationale for extending the Secretary of State's powers. All of these clauses were agreed to on division.[84]

4.12 The Health Services Safety Investigations Body

Part 4 of the Health and Care Bill would replace the current non-statutory HSIB (Healthcare Safety Investigation Branch) with a new statutory, independent, arm's-length investigating body called the Health Service Safety Investigations Body (HSSIB).

Appointments to the HSSIB board

The Opposition introduced a number of amendments to Clauses 93 to 95, largely relating to the membership and responsibilities of HSSIB's board, and the appointments process for board members (**Amendments 101, 122-125** and **127-135**). Justin Madders said limiting the Secretary of State's powers to appoint and approve HSSIB's leadership was important in maintaining its independence, public trust, and support for its work.[85]

Amendment 101 would have aimed to ensure that HSSIB would maintain its independence following any direction from the Secretary of State to carry out an investigation, and that HSSIB could request additional funding in order to carry out the directed investigation.[86]

Amendment 127 would have removed the responsibility of the Secretary of State to appoint the chair and non-executive members to HSSIB's board, and would instead have given that responsibility to the chief executive of NHS England. **Amendment 128** would have removed the need for the Secretary of State to consent to the appointment of the chief investigator of HSSIB. **Amendments 130** and **131** sought to limit the involvement of the Secretary of State in the appointment of non-executive members.[87]

Edward Argar explained HSSIB will be a non-departmental public body and the Secretary of State is responsible to Parliament for NDPBs. It is, he said, standard practice for executive positions to be approved by the Secretary of State to ensure ministerial and democratic oversight. He also noted it is

83 PBC Deb 19 October 2021 c548
84 PBC Deb 19 October 2021 cc541-553
85 PBC Deb 19 October 2021 cc558-564
86 PBC Deb 19 October 2021 c571
87 PBC Deb 19 October 2021 cc553-4

standard practice to have the Secretary of State appoint non-executive board members to public bodies. He added that making that the responsibility of the chief executive of NHS England could also "...bring into question HSSIB's independence, especially when it is investigating issues that might involve or lead to recommendations for NHS England."[88]

The Minister hoped to reassure the Committee that the non-executive member appointments would be bound by the Cabinet Office's governance code on public appointments, which are regulated by the Commissioner for Public Appointments.

With regard to the appoint of HSSIB's chief investigator, the Minister said having the appointment approved by the Secretary of State gives Parliament the ability to hold the Secretary of State to account. He argued that removing this approval process could weaken parliamentary accountability. He said an "important balance has been achieved with the current drafting":

> We have not provided for the Secretary of State simply to appoint the chief investigator. The non-executive members will appoint the chief investigator with the consent of the Secretary of State. That approach will ensure that HSSIB's board is content with the appointment and can use its expertise in such an appointment decision, while we still ensure that there is ministerial oversight and, ultimately, accountability to Parliament.[89]

The only Opposition amendments to this part of the Bill on which the Committee voted were Amendments 101, 130 and 131, which were all rejected. The Committee voted on the question of whether clauses 90 to 92 should stand part of the Bill; this was agreed. Clause 113, which provides for intervention by the Secretary of State should the HSSIB fail significantly to carry out its functions, or fail to carry them out properly, was also voted on and agreed to.[90]

Disclosure of HSSIB information

Clause 106 prohibits the disclosure of "protected material" obtained by HSSIB as part of its investigations. The Government has said the aim is to create a 'safe space' for participants during the investigation, enabling them to "speak openly and candidly with the HSSIB". The safe space also applies to protected material obtained before HSSIB decides whether to investigate.[91]

Subject to certain exemptions, the prohibition on the disclosure of protected materials would encompass any information, document, equipment, or other items held by HSSIB in connection with its investigations relating to a qualifying incident, or that had not been lawfully made available to the public.

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88 PBC Deb 19 October 2021 c555

89 Ibid

90 PBC Deb 26 October 2021 c628

91 Explanatory Notes the Health and Care Bill 2021-22, para 877

Exemptions to the prohibition are set out in Schedule 14 to the Bill. They include if disclosure is:

- necessary for the purposes of carrying out the HSSIB's investigation function;
- necessary for the prosecution or investigation of an offence;
- believed to be necessary to address a serious and continuing risk to the safety of a patient or the public;
- ordered by the High Court; and
- required by a coroner.

Dr Whitford moved **Amendment 86** to Clause 106, that would have define more closely the materials covered by the "safe space" protection. This amendment was also tabled in the name of the Labour members of the Committee by Sir Bernard Jenkin and Jeremy Hunt. The amendment was discussed alongside a number of other amendments and stand part for Clauses 106-109, 117 and Schedule 14.[92]

Amendments 86-91 were also tabled in the name of Sir Bernard Jenkin and Jeremy Hunt as well as Opposition members of the Public Bill Committee.[93] Amendments to this section of the Bill which were debated alongside Amendment 86, included:

- **Amendment 87**, which was consequential on Amendment 86; **Amendment 91**, in Schedule 14, to remove the provision allowing coroners to require the disclosure of protected material; and **Amendment 90**, which was consequential on Amendment 91 (Amendments 87, 90 and 91 were only tabled in the names of Dr Whitford, Sir Bernard Jenkin and Jeremy Hunt).
- **Amendment 88**, in Clause 107, to remove the ability of the Secretary of State to make regulations authorising disclosure of protected material beyond that provided for in the Bill; and Amendment 89, in clause 108, which was consequential on Amendment 88.
- The Labour frontbench tabled **Amendment 136**, in Schedule 14, which Justin Madders described as a probing amendment. This amendment would have given the Chief Investigator the discretion to disclose information about an investigation to a patient/family deemed appropriate on condition the information remained confidential.[94]

Summing up a lengthy debate, the Minister said:

92 PBC Deb 26 October 2021 c601-2

93 Rt Hon Jeremy Hunt is chair of the Health and Social Care Committee as well as a former Secretary of State for Health. Sir Bernard Jenkin was formerly the chair of the Public Administration and Constitutional Affairs Committee (PACAC); both were early proponents of HSIB.

94 PBC Deb 26 October 2021 c601-2

> Safe space is an exciting and important development of recent years. What we are seeking to do today is a first for a health body in this country. The clauses are of great importance to the new HSSIB and the vision we have for it. The novelty of what we are seeking to do here, building on what happens in the transport space, and the challenges that that poses, are demonstrated in the debate we have had on what the right balance is. It is an incredibly difficult and, to a degree, subjective judgment for Members of this House and others to make. While I have set out where we believe it should sit, I entirely respect the perspective of the hon. Member for Central Ayrshire [Dr Whitford], who has a slightly different and entirely legitimate view. I commend the clauses to the Committee.[95]

Dr Whitford acknowledged the Minister was struggling with exactly how to achieve the right balance. She said, "The Minister talks about clarity, but then we hear about flexibility. It is important that we get this right in the Bill." She therefore pressed Amendments 86, 88 and 91 to a vote and all three were rejected.[96]

The Secretary of State's powers of direction in relation to safety investigations (Clause 36)

Clause 36 provides powers of direction for the Secretary of State over NHS England, or any other public authority, in relation to safety investigations.

Justin Madders moved Amendment 108 to specify that the Secretary of State's powers to direct the Health Services Safety Investigation Branch (HSSIB) in this section of the legislation would not supersede the contents of part 4 of the Bill. He said the amendment would ensure the powers in Clause 36 do not in any way impede the important principle that HSSIB will be an independent body established by the Bill.[97] The Minister attempted to reassure the shadow Minister that Clause 36 could not be used to direct the new HSSIB in how it exercises its functions but "…is there simply to ensure the continuity of current investigations during a transitional period." He noted:

> …the merger of NHS England and NHS Improvement means that the NHS Trust Development Authority, of which the Healthcare Safety Investigation Branch is a part, will be abolished. We need the important investigation function that the Healthcare Safety Investigation Branch provides to continue until HSSIB is fully operational which, subject to parliamentary approval, is planned for spring 2023. The power set out in clause 36 is designed to enable the Secretary of State to direct NHS England, or another public body, to carry out the investigation function in the interim period.[98]

95 PBC Deb 26 October 2021 cc618-9
96 PBC Deb 26 October 2021 cc619-20
97 PBC Deb 21 September 2021 c389
98 PBC Deb 21 September 2021 c390

Mr Madders said he was somewhat reassured but, as the Committee considerations had yet to reach part 4 of the Bill which covers the HSSIB, he chose to push the amendment to a vote. Amendment 108 was rejected.[99]

4.13 Provisions relating to adult social care

Hospital discharge (Clause 78)

Clause 78 revokes the requirement for social care needs assessments to be carried out prior to a person's discharge from hospital. The intention is to allow local areas to adopt a discharge model suitable to their needs, including the "discharge to assess" model.

Amendment 98, tabled by the Opposition, would, among other things, have required a social care needs assessment to be carried out by the relevant local authority within two weeks of the patient being discharged from hospital. It would have given Integrated Care Boards a role in monitoring the arrangements.

Alex Norris cited support from local government for Clause 78 as the reason why the Opposition sought to "improve rather than prevent this innovation." However, he raised concerns about a large number of people "[becoming] family carer's overnight" if carer's assessments are to take place post-discharge. He added, "By the time they get the carer's assessment, they may well have been struggling to cope for a significant period of time."[100]

Mr Norris also raised concerns from the British Association of Social Workers that the clause could lead to the "medicalisation of people's journeys out of hospital", with the contribution of social workers marginalised and the voice of the individual lost.[101]

He argued a maximum two-week wait was "prudent" and that the discharge process, which "touches on the borders between institutions", ought to be within the purview of integrated care boards.[102]

In response, Edward Argar said he appreciated the intention of the amendment but was "not sure that it is the best way to advance that objective." "By way of reassurance" he added, where local areas follow the discharge to assess model, unpaid carers are still entitled to a carer's assessment where they are not able to care or need help. This should, he

99 Ibid
100 PBC Deb 23 September 2021 c496
101 Ibid
102 PBC Deb 23 September 2021 c497

said, "be undertaken before caring responsibilities begin for a new caring duty or if there are increased care needs."[103]

Mr Argar also cited evidence that long-term care assessments are best carried out at the point of optimum recovery and that requiring them to be completed within two weeks of discharge would "create an extra layer of bureaucracy." He raised a concern that introducing penalties for local authorities if they fail to carry out assessments within the deadline could "create a tension within the system, which would go against the spirit of the integrated working that the Bill seeks to support."[104]

The amendment was rejected following a vote and the Clause was agreed without a vote.[105]

CQC assessment of local authority social care functions (Clause 121 and New Clauses 60 and 61)

Clause 121 provides for the Care Quality Commission (CQC) to be placed under a duty to assess local authorities' delivery of their adult social care functions under Part 1 of the Care Act 2014.

New Clause 60, tabled by the Government, would provide the Secretary of State with powers to intervene where local authorities are failing to discharge their functions under part 1 of the Care Act 2014 to an acceptable standard. The Minister said the Government's priority will be to support local authorities to lead their own improvement where issues are identified. He added, however, that "where CQC assessment identifies a persistent and serious risk to people's wellbeing and local authorities are unable to lead their own improvement, it is right that the Government have powers to step in and help secure that improvement."[106]

For the Opposition, Alex Norris expressed concern that the new clause represented "a considerable overreach" in inserting the Health Secretary into accountability processes for local government. A "continued pattern" with the Bill, he argued, was that "integration is a bit of a myth, but where there is any, it is largely that the health service ought to have more power and, more importantly, that the Secretary of State ought to have more power over telling local government what to do."[107]

New Clause 60 was agreed following a vote.[108]

New Clause 61, also tabled by the Government, would remove the power of the Care Quality Commission to give a notice of failure to an English local authority. The Minister explained the change was being proposed in light of the new

103 PBC Deb 23 September 2021 c499
104 Ibid
105 PBC Deb 23 September 2021 cc495-502
106 PBC Deb 26 October 2021 c647
107 PBC Deb 26 October 2021 cc643-649
108 PBC Deb 27 October cc701-703

approach to assurance and support, as provided by Clause 121. He explained that, under the proposed new arrangements, "where the CQC identifies failure, it may make recommendations to local authorities. It must also notify the Secretary of State of the failure and advise him on possible next steps to secure improvement."[109]

For the Opposition, Mr Norris, said he suspected the new clause was a reflection that the Health Secretary will "command and control the system". He added he "did not think this is adequate in local government, given the mandate that our councillors get from their population."[110]

The new clause was agreed following a vote.[111]

Amendment 145, tabled by the Opposition, would have required the CQC to ensure the "direct involvement of both users and providers of services" when it carries out a review under Clause 121. Mr Norris said the aim was to ensure "those with the greatest stake and the greatest expertise by experience have the chance to be part of the process."[112]

The Minister said he sympathised with the aims of the amendment and said the Government's intention was that reviews by the CQC "should draw upon a wide range of information and perspectives from the sector, including from providers and service users." He added, however, that more detailed information on how the CQC reviews will be undertaken will be provided in a "method statement", which the CQC will develop, and the Secretary of State will approve. He suggested this statement is the more appropriate place to set out operational details of how reviews will be conducted.[113]

Mr Norris said the Minister's comments on the amendment "provided great comfort" and he withdrew it. He added the Opposition would not oppose Clause 121 "because there needs to be some oversight in the new environment that the Government are seeking to create."[114]

Clause 121 was agreed without a vote.[115]

4.14 Financial assistance to adult social care providers (Clause 122)

Clause 122 provides the Secretary of State with power to provide financial assistance to adult social care providers. Currently, while the Secretary of

109 PBC Deb 26 October 2021 c647
110 PBC Deb 26 October 2021 cc643-649
111 PBC Deb 27 October cc703-704
112 PBC Deb 26 October 2021 c643
113 PBC Deb 26 October 2021 c646
114 PBC Deb 26 October 2021 cc643-649
115 PBC Deb 26 October 2021 c652

State may provide financial assistance to "qualifying bodies" delivering adult social care, this does not include providers operating for profit, and thus excludes much of the adult social care provider market.

The Minister said the new power provided by the clause will "allow the Secretary of State to react to unforeseen and changing circumstances by directing financial assistance to social care providers with greater speed and in a more targeted manner." He added that the coronavirus pandemic has demonstrated the need for such a power.[116]

Alex Norris said the Opposition did not oppose the principle behind the clause, but he sought reassurance that it "will not lead to the routine commissioning of private providers outside the commissioning plans of local authorities." In response, the Minister emphasised that "there is no intention…to in any way go round or replace the current commissioning functions of the local authority."[117]

The clause was agreed to without a vote.[118]

4.15 International healthcare (Clause 120)

Clause 120 amends the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 to enable the Government to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland.

The Explanatory Notes say the exact arrangements provided for under any future reciprocal healthcare agreements will be a matter for negotiation.[119] Unlike most other provisions in the Bill, the territorial extent and application of this clause includes Wales, Scotland, and Northern Ireland, as well as England.

Amendment 110, moved by Dr Whitford (SNP), would have remove devolved Ministers from the definition of a "public authority" on which the Secretary of State could confer functions, or to which the Secretary of State could delegate functions, under this section.

This was discussed alongside **Amendment 111**, that would have required the Secretary of State to obtain the consent of devolved governments before regulations under section 2 of the renamed Healthcare (International Arrangements) Act 2019 could be made. The Committee also discussed Labour's **Amendment 146**, to make regulations giving effect to a healthcare

116 PBC Deb 26 October 2021 c653
117 PBC Deb 26 October 2021 c654
118 PBC Deb 26 October 2021 cc653-654.
119 Explanatory Notes the Health and Care Bill 2021-22, 923

agreement subject to the affirmative resolution procedure.[120] This amendment would have also required a proposal for such regulations and an impact assessment to be laid before Parliament before any such regulations could be brought forward.

Dr Whitford said the devolved nations, and the Ministers concerned, were not involved in the development of this section of the Bill, and there is "no mention of how they will be involved in shaping any healthcare agreements or health insurance card. That is what we are now calling for."[121]

Edward Argar reiterated the UK Government's commitment to meaningful and ongoing engagement with the devolved administrations on reciprocal healthcare. He noted there is already a statutory obligation under the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 to consult the devolved administrations before making any regulations under the Act in areas within the competence of the devolved legislatures. He said the UK Government is working with officials in the devolved administrations on the development of a memorandum of understanding setting out how that duty is fulfilled in practice, and it undertakes "to engage and consult the devolved Administrations, not just at the end of the implementation stage but from a much earlier stage." He said "...good progress is being made, but I suspect that on Report, I will have to report back on where we have got to."[122]

Amendment 110 was withdrawn and Amendment 146 was rejected following a vote.[123]

4.16 Pharmaceutical services (New Clause 62)

The Government introduced **New Clause 62** to provide for circumstances where community pharmacies and other dispensing services do not have to be paid to supply medicines because stocks have been centrally purchased by the NHS (community pharmacists and dispensing doctors are usually paid to cover the cost of purchasing the medicines they dispense.

The explanatory text for the new clause said it would expand a power to make regulations under section 164 of the National Health Services Act 2006 (which, among other things, provides for circumstances in which no remuneration needs to be paid to persons who provide pharmaceutical

[120] Affirmative procedure is a type of parliamentary procedure that applies to statutory instruments (SIs). An SI laid under the affirmative procedure must be actively approved by both Houses of Parliament. Further information on SI procedure is available on the Parliament website.

[121] PBC Deb 26 October 2021 c634

[122] PBC Deb 26 October 2021 c636

[123] PBC Deb 26 October 2021 c642

services in respect of products because they are supplied by a health service body).[124]

Edward Argar said the new clause is important to ensure that centrally purchased stock of essential medicines intended for patients in England can be distributed to community pharmacies to meet clinical need and support patient access, including for vaccination or treatment in connection with a pandemic.[125] New Clause 62 was agreed and added to the Bill.

4.17 Professional regulation (Clause 123)

Clause 123 extends the scope of existing powers under section 60 of the Health Act 1999 to enable changes to be made to the professional regulation system applying to healthcare staff through secondary legislation. The Explanatory Notes say powers sought through this Bill "…form part of a wider programme aiming to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public."[126]

Dr Whitford moved **Amendment 112** to Clause 123, to require the Secretary of State to obtain consent from devolved governments before using section 60 of the Health Act 1999, where such legislation would affect the devolved administrations.[127]

Dr Whitford highlighted concerns that the Secretary of State will have the power to abolish certain regulatory bodies or deregulate certain professions through secondary legislation. While acknowledging that most registration and regulatory bodies for healthcare are UK-wide, she said "…it must be recognised that people work and move between the four nations, so anything that happens at [the UK level] will have an impact on the devolved health services."[128] She also raised concerns about a lack of consultation with the devolved administrations if there were to be significant changes:

> We face the potential of new grades or qualifications being created that the devolved health services would have no option other than to recognise and accept, yet they would have minimal input, so we are back to the issue of genuine consultation with and consent from Health Ministers.[129]

After setting out the benefits of regulating health and care professionals on a UK-wide basis, Mr Argar said the UK Government "…value and will continue

124 PBC Deb 27 October 2021 c704
125 PBC Deb 27 October 2021 c706
126 Explanatory Notes the Health and Care Bill 2021-22, para 162
127 PBC Deb 26 October 2021 c654
128 Ibid
129 PBC Deb 26 October 2021 c655

to work collaboratively with our devolved Administration partners on the regulation of health and care professionals."[130]

Justin Madders moved **Amendment 142**, to introduce a legislative requirement in section 60 of the Health Act 1999 for health and care professional regulators to raise professional awareness of rare and less common conditions where possible. He said the Opposition were seeking to find ways of increasing awareness of rare and less common conditions among healthcare professionals, although he accepted the amendment "may not be a perfect vehicle".[131] It was withdrawn after a short debate.[132]

Clause 123 was agreed following a vote.

4.18 Restrictions on advertising less healthy food and drink (Clause 125)

Schedule 16 would amend the Communications Act 2003 (CA 2003) to insert new sections 321A and 368FA. These would enable Ofcom to prohibit advertising of less healthy food or drink between the hours of 5.30 am to 9 pm on TV, and on those on-demand programme services that are regulated by Ofcom. Proposed new section 368Z14 would prohibit paid-for advertising of less healthy food and drink online. These new advertising restrictions are an important part of the Government's strategy to tackle childhood obesity and help promote public health. In Committee, there was broad cross-party support for that goal.

If enacted, the measures contained in Schedule 16 of the Bill would come into force on 1 January 2023 and would apply to the whole of the UK. The Library briefing on Obesity explains the background to the proposed advertising restrictions.[133]

Clause 125, which inserts Schedule 16 into the Bill, was considered during the seventeenth sitting of the Public Bill Committee (26 October 2021). None of the tabled amendments were pressed to a vote. However, during the debate on **New Clause 55**, introduced by the Opposition, the Minister made a commitment to table an amendment to Schedule 16 on Report to require the Secretary of State to consult before making any changes to guidance for less healthy food and drink advertising. There was a stand part debate on Clause 125 and Schedule 16.

Amendment 113, moved by Dr Whitford (SNP), would have required the Secretary of State to obtain the consent of the devolved assemblies before any of the regulation-making powers granted by Schedule 16 of the clause

130 Ibid
131 PBC Deb 26 October 2021 c656
132 Ibid
133 Obesity, Commons Library briefing CBP-9049

were exercised. The Minister said that the UK Government had made it clear that the primary purpose of the provision on the advertising of less healthy food and drink on TV and internet services is to regulate content on reserved media, the internet and broadcasting. On that basis, it holds to the view that it is reserved.[134] The Minister accepted Dr Whitford's point that a joined-up approach to public health across the four nations of the UK was beneficial but did not think it necessary to put a requirement to 'consult' in the Bill.[135] Dr Whitford withdrew her amendment but asked the Government to reconsider and add consultation requirements to the Bill.[136]

Amendments 139 to **141** would have expanded the definition of 'less healthy' products to include alcohol, which would have the effect of making alcohol advertising liable to the watershed proposed for TV programme services, and to the online restriction of paid-for advertising. Speaking to these amendments, Alex Norris said the removal of alcohol from the obesity strategy was an area where the Opposition disagreed with the Government. These were probing amendments designed to find out more about the Government's thinking on this issue.

The Minister suggested less healthy food and drink products are unique, as they are not age-restricted at the point of purchase, unlike alcohol.[137] He said the Government was committed to protecting children and young people from alcohol advertising through the UK advertising codes, which apply to broadcast and non-broadcast media, including online advertising.[138] If new evidence emerges that highlights major problems with the existing codes, the Advertising Standards Authority has a duty to take appropriate action. For these reasons, the Minister said the Government did not believe it necessary to consider alcohol a less healthy product in this context, or to apply the new restrictions to it.[139]

New **Clause 55** would have required a consultation before any changes could be made to the Nutrient Profiling Model (NPM) used for the purposes of regulations under the CA 2003 or any other enactment. The Minister said Schedule 16 already provides for a two-step approach to determine whether a product is less healthy. The Secretary of State would have the power to make regulations to change the meaning of the relevant guidance, but it would be subject to the affirmative procedure to ensure parliamentary scrutiny. Although work has been under way over the past three years to update the NPM, the Government was clear in past consultations on the new advertising restrictions[140] that if it wanted to use the updated NPM it would need to

134 PBC Deb 26 October 2021 c674
135 Ibid
136 PBC Deb 26 October 2021 c679
137 PBC Deb 26 October 2021 c675
138 PBC Deb 26 October 2021 c675
139 Ibid
140 Further advertising restrictions on TV and online products high in fat, sugar and Salt (HFSS), Department of Health and Social Care & Department for Digital, Culture, Media and Sport, 18 March 2019; Total restriction of online advertising for products high in fat, sugar and salt (HFSS),

consult with stakeholders. Nevertheless, to reassure the Committee, the Minister said he would table an amendment to Schedule 16 on Report to require the Secretary of State to consult before making any changes to relevant guidance.[141] This amendment would be minor, technical and would not change policy intent nor would it affect other powers in the Bill.[142]

During the stand part debate on clause 125 and Schedule 16, Mr Norris asked how the decision to prohibit online advertising of less healthy food and drink products was reached, it was his understanding that those working in the digital media advertising sector had offered a solution that would act as a 'de facto' ban for children without being an outright ban.[143] The Minister said the reason why there is no watershed equivalent online is that it reflects the nature of online media: it is on demand, rather than linear, as with a terrestrial or satellite broadcast.[144]

Questions were asked about who would be held liable for breaches of the advertising restrictions. The Minister explained that under Schedule 16 broadcasters and UK-regulated on-demand programme services would be liable for any breaches of the 9 pm TV watershed. Advertisers would be liable for breaches across on-demand programme services not regulated by Ofcom and the paid-for online advertising prohibition.[145] Edward Timpson thought this was a missed opportunity; despite being the publisher and having control of the content, online platforms would have no responsibility for anything that goes wrong:

> The Government's response states that the extent of a platform's liability for unlawful advertising generally would be considered as part of its online advertising programme, and that it would be for the regulators to determine whether an online platform should be treated as an advertiser. That is where the ambiguity lies. There is a chance to make those expectations clearer through primary legislation or in regulation.[146]

In respect of the prohibition on paid-for advertising of less healthy food and drink online and the 9 pm TV watershed, Schedule 16 contains an exemption for SMEs. Mr Norris asked why this exemption was necessary.[147] Dr Whitford thought the exemption could create a loophole with large companies simply employing multiple small advertisers or restructuring themselves to continue advertising.[148] Hywel Williams sought clarification on whether this SME exemption would apply to micro businesses and umbrella trade bodies.[149]

Department of Health and Social Care & Department for Digital, Culture, Media and Sport, 10 November 2020

141 PBC Deb 26 October 2021 c678-9

142 Ibid

143 PBC Deb 26 October 2021 c670

144 PBC Deb 26 October 2021 c673

145 PBC Deb 26 October 2021 c677-678

146 PBC Deb 26 October 2021 c672

147 PBC Deb 26 October 2021 c670-671

148 PBC Deb 26 October 2021 c669

149 PBC Deb 26 October 2021 c673

The Minister stressed the exemption would only apply to SMEs. The definition of an SME would be set out in secondary legislation, and the Government intended to consult on these regulations towards the end of this year or the beginning of next year.[150]

4.19 Water fluoridation (Clauses 128 and 129)

Clauses 128 and 129 of the Bill would amend the Water Industry Act 1991 to give the Secretary of State powers to directly introduce, vary or terminate water fluoridation schemes in England.[151] These changes would mean the Secretary of State would no longer need to be directed by a local authority to establish a water fluoridation scheme.

The Explanatory Notes to the Bill highlight difficulties with the current process, such as discrepancies between water flow boundaries and local authority boundaries. The Explanatory Notes say the amendments would remove "the burden from local authorities and will allow DHSC to streamline processes and take responsibility for proposing any new fluoridation schemes, which will be subject to consultation and funding being agreed."[152]

A brief background on the proposals in the Bill and on water fluoridation in general is provided in the Library paper, Health and Care Bill 2021-22. A more detailed discussion on dental health in England, the evidence on water fluoridation and public attitudes is provided in an August 2021 POSTnote, Water fluoridation and dental health.

Amendments were tabled to Clauses 128 and 129 at Committee stage but these were withdrawn and the clauses passed unamended.

Alex Norris, moved **Amendments 149, 150** and **151** to Clause 128.[153]

The Bill as currently drafted provides the Secretary of State is responsible for introducing water fluoridation schemes and does not have to be directed by a local authority to do so. Amendments 149 and 150 would have meant both the Secretary of State and a local authority could commence water fluoridation schemes.

Mr Norris said the Opposition supported the principle behind Clause 128 and noted benefits to the Secretary of State having this role, such as being able to commence water fluoridation schemes beyond local authority boundaries. However, he said local authorities should retain powers in relation to introducing fluoridation schemes. He said the amendment "merely expands

150 PBC Deb 26 October 2021 c677
151 Health and Care Bill, Parliament.uk
152 Explanatory Notes the Health and Care Bill 2021-22, para 205
153 PBC Deb 26 October 2021 c684

the range of possible approaches and paths towards fluoridation, and it promotes local decision making."[154]

Edward Argar responded to the amendment. He said transferring the responsibility to central government would remove the limitations of local authority boundaries, and to continue to allow local authorities to commence schemes would conflict with the Government's plan to manage expansion centrally, and would add "extra complexity."[155] However, he noted the action being taken by local authorities in this area and said the Government shared the ambition to expand water fluoridation schemes and would "engage and listen to local areas so that together we can make the biggest impact on oral health improvement that we know fluoridation will provide."[156]

Mr Norris also spoke to Amendment 151 which sought to ensure the costs of water fluoridation were not passed on to public bodies such as local authorities. He said currently, Public Health England was required to meet the costs of a water fluoridation scheme but clause 128 removed that requirement and instead would allow the Secretary of State to direct another body to pay for the scheme.[157]

Mr Argar said there were no current proposals for cost sharing and the provisions had been discussed with NHS England, NHS improvement and the Local Government Association. He said he could "assure the Committee that should we bring forward any plans to cost share in the future, we would seek to fully engage with relevant groups at the earliest opportunity."[158] He also explained that any plans to cost share would require regulations which would be the subject of consultation.

The amendments were withdrawn.

4.20 Prohibition of 'virginity testing' and hymenoplasty (New Clauses 1 and 2)

Several MPs from across Parliament tabled New Clause 1 to prohibit 'virginity testing', and New Clause 2 to prohibit hymenoplasty.[159]

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154 PBC Deb 26 October 2021 c685

155 PBC Deb 26 October 2021 c687

156 PBC Deb 26 October 2021 c687

157 PBC Deb 26 October 2021 c685

158 PBC Deb 26 October 2021 c688

159 Further information on virginity testing and hymenoplasty can be found in the Royal College of Obstetricians and Gynaecologists' position statement Virginity testing and hymenoplasty (August 2021) (409KB, PDF). The RCOG statement describes hymenoplasty as "a procedure undertaken to reconstruct a hymen. This is done by creating scar tissue in the vagina, with the purpose of allowing a woman to bleed the next time she has intercourse, in order to give the impression that she has no history of vaginal intercourse."

Speaking on the new clauses, Alex Norris read a statement from the Royal College of Obstetricians and Gynaecologists':

> There is no reason why either virginity testing or hymenoplasty, or any other procedure under a different name that seeks to reconstruct or repair the hymen, would need to be carried out for medical purposes. Both are harmful practices that create and exacerbate social, cultural and political beliefs that a women's value is based on whether or not she is a virgin before marriage.[160]

Edward Argar, said the Government was "entirely aligned" on the policy objectives and intent of New Clause 1 but that there were several drafting and other factors that the Government needed to work on before it would be able to create legislation. He reassured the Committee that the Government had plans to introduce its own legislation "at the nearest opportunity".[161]

The Minister said the Government shared the concerns underpinning New Clause 2, which would ban hymenoplasty, but that initial reviews had indicated "…no clearly defined consensus on whether hymenoplasty should be banned."[162] He noted the Government's tackling violence against women and girls strategy, had said an expert panel would be created to explore the clinical and ethical aspects of the procedure in more detail.

Edward Argar added that the recommendations of the panel "…will need to be fair, objective and based on evidence, so I hesitate to go beyond that in expressing a view on the substance of the new clause until I have that expert panel report before me."

The Minister said the intention is to publish the report of the expert panel before the Christmas 2021 recess, and depending on its contents, "…bring forward legislation if or as appropriate, considering everything it contains in the context of vulnerable women and girls' safety."[163]

Alex Norris said he took "great encouragement" from the Minister's response and withdrew New Clause 1 (New Clause 2 was not formally called).[164]

On the 18 November 2021 several Government amendments to the Bill have been tabled for consideration at Report, to create a number of offences in relation to virginity testing (with separate provisions relating to the law in England and Wales, Scotland, and Northern Ireland). As well as prohibiting virginity testing, these amendments would establish offences of "offering to carry out virginity testing" and "aiding a person to carry out virginity testing", in circumstances where the carrying out of that testing might not itself be an

160 PBC Deb 27 October 2021 c709
161 PBC Deb 27 October 2021 c711
162 PBC Deb 27 October 2021 c713
163 PBC Deb 27 October 2021 cc712-3
164 PBC Deb 27 October 2021 c713

offence (depending on the location or status of the person carrying out the testing).[165]

4.21 Tobacco regulation

There were no clauses relating to tobacco regulation within the Bill as introduced.

New Clauses 29-38 were moved by Mary Kelly Foy (Labour), Vice-Chair of the All-Party Parliamentary Group (APPG) on Smoking and Health. They are based on recommendations from the most recent APPG report Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021.[166]

Most of the amendments were withdrawn. New Clauses 31 and 32 were pushed to a division in Committee and were defeated.

The amendments have been re-tabled for consideration on Report.[167]

Background on recent Government policy on tobacco regulation, and an upcoming Government Tobacco Control Plan is provided in a Library briefing, Delivery of a new Tobacco Control Plan.[168]

The new clauses included several proposed measures that would impact on the sale of tobacco products:

- **New Clause 29** would give powers to the Secretary of State to require manufacturers to print health warnings on individual cigarettes.
- **New Clause 30** would give powers to the Secretary of State to require the inclusion of leaflets with information about health and smoking cessation services in cigarette packaging.
- **New Clause 31** would give powers to the Secretary of State to make requirements for labelling and advertising of e-cigarettes and other products to make them less appealing to children.
- **New Clause 32** would give powers to the Secretary of State to ban the sale/free distribution of nicotine products to under 18s (whilst allowing the sale or distribution of licenced nicotine products for use in under 18s)

165 Health and Care Bill: Notices of Amendments as at 18 November (287KB, PDF)

166 Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021, June 2021

167 Health and Care Bill, Notices of Amendments as at 18 November 2021

168 Delivery of a new Tobacco Control Plan, Commons Library debate briefing, CDP-2021-0192, 15 November 2021.

- **New Clause 33** sought to remove the limitations on the prohibition of flavourings of smoking products and give the Secretary of State the powers to ban all flavourings in tobacco products and smoking accessories.

- **New Clause 34-37** would make provision for the Secretary of State to establish a new scheme to regulate the prices of tobacco products and the profits from the manufacture and sale of these products. These clauses also included provisions relating to enforcement and processes involved in establishing such a scheme.

- **New Clause 38** would give the Secretary of State the powers to ban the sale of tobacco products to individuals under the age of 21.

Moving the amendments, Ms Foy highlighted the Government's commitment to make England smoke free by 2030 and said "two years on, and with less than nine years to go before 2030, we are nowhere near on track to achieve that ambition."[169] She said the new clauses were based on the recommendations of the latest APPG report on Smoking and Health and set out a "range of complementary measures to deliver the smoke free ambition, which will also significantly increase productivity and reduce pressure on the health and care system."

Ms Foy described New Clauses 29, and 30 (on printed health warnings on cigarettes and providing health information) as "simple, uncontroversial and effective measures that would help deliver the Government's smoke-free 2030 ambition at minimal cost."[170] She said Clauses 31 and 32 would allow the Secretary of State to close loopholes in relation to the marketing and distribution of tobacco products and e-cigarettes to individuals aged under 18.[171] She said the current legislation only banned sales to this group and did not restrict them being distributed for free, describing this as a "shocking loophole in the law."[172]

New Clause 33 would ban all flavouring in tobacco products. Ms Foy explained the current ban on flavourings of tobacco products only included those where the flavouring was defined as characterising, she said this "has allowed tobacco manufacturers to drive a coach and horses through the legislation."[173] She said the Government had not yet reported back on its review of tobacco legislation and it was "time for them to address these egregious loopholes in the regulations, and the Bill is an ideal opportunity to do so."[174]

Edward Argar said the Government were sympathetic to the aims of New Clause 29 and strongly supported measures to stop people smoking.

169 PBC Deb 26 October 2021 c806
170 PBC Deb 26 October 2021 c806
171 PBC Deb 26 October 2021 c807
172 PBC Deb 26 October 2021 c807
173 PBC Deb 26 October 2021 c807
174 PBC Deb 26 October 2021 c812

However, he said further research, and a more robust evidence base was needed before introducing additional measures. He said as part of the new tobacco control plan, the Government were exploring a "broad range of new regulatory measures to support our ambition to be smoke free by 2030" including this proposal.[175]

In response to New Clause 30, Mr Argar said the Government believed this new power was not necessary as powers within the Children and Families Act 2014 already made legislating on this issue possible. He also noted the graphic images, health warnings, and information about the NHS website currently required on tobacco packaging. He explained that the Standardised Packaging of Tobacco Products Regulations 2015 prohibit the use of inserts in packaging and if the Government were to introduce inserts, further research would be needed.

Responding to New Clause 31, the Minister said the Government were undertaking a post-implementation review of the Tobacco and Related Products Regulations 2016 to be published later in 2021. He set out that current regulations "include requirements on the packaging and labelling of e-cigarettes, along with restrictions on marketing, and they prohibit advertising on mainstream media such as TV and radio for e-cigarettes." He said the Government strongly supports measures to protect young people but again highlighted the need for the post-implementation reviews and further research in this area. He said powers to ban sales to under-18s in New Clause 32 were not needed, as there were existing powers in the Children and Families Act 2014 to extend these to other products. He said there was no robust evidence to suggest the free distribution of nicotine products was a widespread problem.

Mr Argar said the Government were sympathetic to the aims of New Clause 33, which intended to prohibit all flavours in tobacco products and accessories. However, he said it was "not clear how a ban on flavours would be enforced in practice, as it would include a ban on flavours that do not give a noticeable flavour to the product."[176]

Ms Foy welcomed the Government's commitment to publishing the new plan and consideration of the policies in the New Clauses. She withdrew the majority of the new amendments but pushed New Clauses 31 and 32 to a division. New Clause 31 was defeated by 8 votes to 6. New Clause 32 was defeated by 8 votes to 5.[177]

Ms Foy said that to meet the commitment of England being smoke free by 2030, young people need to be prevented from starting smoking when they were most susceptible to it. She noted a University College London Survey finding that there was a"25% surge in the number of young adults aged 18 to 34 in England who smoked during the first lockdown."[178] New Clause 38 would

175 PBC Deb 26 October 2021 c813
176 PBC Deb 26 October 2021 c815
177 PBC Deb 26 October 2021 c817-18
178 PBC Deb 26 October 2021 c807

give the Secretary of State powers to increase the age of sales of tobacco products to 21.

Ms Foy went on to set out the proposals under New Clauses 34-37 relating to powers to introduce a new scheme to regulate tobacco pricing:

> Finally, I want to address the issue of funding. The coronavirus pandemic has meant that the need for more investment in public health is greater than ever before. The Government promised to consider a US-style "polluter pays" levy on tobacco manufacturers in the 2019 prevention Green Paper. New clauses 34 to 37 would enable the Secretary of State to regulate prices and the profits of tobacco manufacturers and importers, which could provide funding not only for England, but for the devolved Administrations, with any excess allocated to other vital public health interventions.[179]

The Minister responded to New Clauses 34-37 together. He highlighted that reducing the affordability of tobacco products, and especially tax increases were effective in encouraging smoking cessation. He said the Government were open to the tobacco industry providing additional funds but said tobacco taxation matters were a matter for the Treasury; any new scheme would likely require years to develop and include several considerations:

> While the Government are open to the idea of the tobacco industry providing additional funds beyond taxation, further consideration of the potential options for and impacts of a scheme, including a robust impact assessment, would be needed. We would also need to consider how such a scheme would be implemented and how it would impact the taxation requirements currently placed on the industry. Such a scheme would likely take a number of years to develop and deliver to ensure that it was effective and robust.[180]

In response to New Clause 38 (which would raise the age of sale of tobacco from 18 to 21), Mr Argar said the Government would like to review the evidence base on this issue in more detail. This would include looking at the "impact on public health, the costs of implementation and how it would be enforced by trading standards."[181] He noted support for the policy from the Royal College of Physicians and the APPG on Smoking and Health and said the Government would look at all proposals as part of the development of the new Tobacco control plan.

New Clauses 34-38 were withdrawn.

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179 PBC Deb 26 October 2021 c807

180 PBC Deb 26 October 2021 c816

181 PBC Deb 26 October 2021 c816

4.22 Consideration of other new clauses

Labour proposed a series of new clauses on a range of issues including maternity safety, NHS income from private patients, public health, NHS 'net zero' commitments, and freedom of information requests to NHS organisations (**New Clauses 23-25, 44-46, 48, 49** and **50**). These were mostly withdrawn without division, although a vote was taken on the new clause proposed by the Opposition on maternity safety.

Justin Madders introduced **New Clause 23**, which would have prevented NHS NHS foundation trusts increasing their income from private patients year-on-year unless certain conditions were met.[182] He also moved **New Clause 24** which would have required NHS trusts to publish Royal College invited review reports.[183] Labour also introduced **New Clause 44** which would have put the duties of local Directors of Public Health on a statutory footing.[184] All were withdrawn without a vote.

Annual parity of esteem report: spending on mental health and mental illness (New Clause 3)

Justin Madders explained the Opposition had "put our name" to **New Clause 3**, which was tabled by Anne Marie Morris. This new clause would have required the Secretary of State to make an annual statement on how the in-year funding received by mental health services from the overall annual allotment had contributed to the improvement of mental health and the prevention, diagnosis and treatment of mental illness.

He said he would not push for a vote on New Clause 3, but wanted to highlight the urgent need for more support for mental health services throughout the UK. New Clause 3 was withdrawn after debate.[185]

Support provided by the NHS to victims of domestic abuse (New Clause 5)

Alex Norris introduced New Clause 5, which had been tabled by Anne Marie Morris and now had Opposition support. This new clause would have required Integrated Care Boards (ICBs) to publish a strategy for the provision of support for victims of domestic abuse using their services and designate a domestic abuse and sexual violence lead.[186]

Edward Argar hoped to reassure the Committee that placing in the Bill a formal duty on ICBs to develop a separate strategy would be unnecessary

182 PBC Deb 27 October 2021 c780
183 PBC Deb 27 October 2021 c783
184 PBC Deb 28 October 2021 c835
185 PBC Deb 27 October 2021 cc714-8
186 PBC Deb 27 October 2021 c718

"and not the best approach". He noted there are already several duties on CCGs to consider the needs of victims of violence, including victims of domestic abuse, and that these will be transferred to and continue to apply to ICBs. He said these duties would be further strengthened by the requirement on ICBs to develop system-level commissioning plans. He added that under the Domestic Abuse Act 2021, local healthcare systems will be required to contribute to domestic abuse local partnership boards.[187]

The shadow Minister said he could not agree with the characterisation that the new clause is unnecessary and went on:

> I accept that we would not want to see a proliferation of further strategies. By making it a requirement, the new clause seeks to put the treatment, assessment and care of domestic abuse on the same footing in integrated care as elective care or major diseases. It should have that status, and at the moment it does not. It needs to be elevated to that level.[188]

The new clause was rejected following a vote.

Duty for the Secretary of State to report on the quality and safety of maternity services (New Clause 25)

Justin Madders introduced a new clause to require the Secretary of State for Health and Social Care to prepare and publish a report on variation in the quality and safety of England's maternity services and disparities in maternal mortality rates in England, including what steps the Department of Health and Social Care is taking to address these disparities and improve outcomes for patients. This new clause was rejected following a vote.[189]

Duty on Integrated Care Boards to have regard to net zero commitment (New Clause 45)

Justin Madders introduced a new clause to place a duty on integrated care boards to have regard to NHS England's commitment to reach net zero by 2040. Edward Argar noted recent NHS England guidance saying:

> Every trust and every ICS is expected to have a Green Plan approved by that organisation's board or governing body. For trusts, these should be finalised and submitted to ICSs by 14 January 2022. Each ICS is then asked to develop a consolidated system-wide Green Plan by 31 March 2022, to be peer reviewed regionally and subsequently published.[190]

The new clause was withdrawn without a division.

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187 PBC Deb 27 October 2021 c722-3

188 PBC Deb 27 October 2021 c724

189 PBC Deb 27 October 2021 cc788-91

190 PBC Deb 28 October 2021 c841

Exclusion of NHS bodies from ability to withhold information requested under the Freedom of Information Act 2000 on commercial grounds (New Clause 46)

Justin Madders introduced a new clause to prevent NHS bodies from withholding information on commercial grounds unless the information relates to another organisation and that organisation considers its disclosure would pose a real and significant risk to its commercial interests.[191]

Mr Madders said there were some instances where individual trusts had been unwilling to share information with NHS staff and unions and had used exemptions for commercially sensitive information under the Freedom of Information Act to avoid proper scrutiny (including information about procurement arrangements and patient safety issues). However, he noted the Minister's concern that the new clause might have unintended consequences and withdrew it.[192]

Protection of title of nurse (New Clause 49)

Labour introduced a new clause to limit use of the title of 'nurse' to those on relevant professional registers, such as those maintained by the Nursing and Midwifery Council (NMC). Justin Madders highlighted the public campaign on this issue, led by Professor Alison Leary, chair of Healthcare and Workforce Modelling at London South Bank University, and others.[193]

Edward Argar said he was sympathetic to the aims of the clause and committed to reviewing the matter. He said such a change would need to be carefully considered, noting examples of some legitimate uses of the title by those who were not part of a statutory register of nurses (such as nursery nurses). The Minister also noted that the title 'registered nurse' was already protected. Mr Madders withdrew the amendment but pushed for a formal consultation on the matter. He said the Opposition would be keeping an eye on progress.[194]

Duty on Secretary of State to review use of innovative treatments (New Clause 50)

Alex Norris introduced a new clause to require the Secretary of State to carry out a review of the assessment and use of innovative medicines and medicinal products, and to consider how to improve access to medicines and medicinal products for people with rare and less common conditions in particular.[195]

191 Ibid
192 PBC Deb 28 October 2021 c841-5
193 PBC Deb 28 October 2021 c845
194 PBC Deb 28 October 2021 c849
195 PBC Deb 28 October 2021 c849

Edward Argar said patients, including those with rare diseases, have access to innovative treatments – and he noted that NHS Digital published an 'innovation scorecard' and committed to strengthening this data. He referred to the 2016 Accelerated Access Review, and said following the review, "the Government, the NHS and partner organisations have worked closely together to increase the use of proven and cost-effective medicines." The Minister also noted existing mechanisms to assess and support medicinal products for rare and less common conditions – including methods developed by NICE and the creation of the Innovative Medicines Fund. He referred to the new UK rare disease framework, published in January 2021, outlining the key priorities for rare diseases in the UK over the next five years.[196]

Alex Norris said he was grateful to the Minister for his full answer and said that he would withdraw the new clause, as ongoing developments in this area should play out before looking at anything else. However, he added that he hoped NICE would engage with parliament on its work.[197]

Duty on Integrated Care Partnerships to prepare and deliver a best start for life strategy (New Clause 51)

Alex Norris introduced a new clause to require each Integrated Care Partnership to prepare and deliver a "Best Start for Life" strategy, in cooperation with relevant bodies. He said this would give ICPs a duty to focus on the crucial early years of childhood development.[198]

The Minister responded that the Government and NHS "are working on bespoke guidance, which will set out the measures ICBs and ICPs should take to ensure that they will deliver for babies, children and young people. That will cover the importance of the ICP integrated care strategies having measurable objectives for babies, children and young people." Mr Norris withdrew the new clause.[199]

Implementing recommendations of the independent medicines and medical devices review (New Clause 52)

Alex Norris introduced a new clause to require the Secretary of State, within six months, to publish a report containing a plan for the implementation in full of the recommendations of the Independent Medicines and Medical Devices review. This review (also known as the Cumberlege Review) considered the experiences of people— generally women—who had been treated with Primodos, sodium valproate or pelvic mesh implants.[200]

The Minister said we wanted to reassure the Committee "the Government take very seriously our responsibility to implement the accepted recommendations

196 PBC Deb 28 October 2021 c852
197 PBC Deb 28 October 2021 c854
198 Ibid
199 PBC Deb 28 October 2021 c858
200 PBC Deb 28 October 2021 c858

at pace." He noted many of the recommendations will introduce large-scale changes to patient safety, and "we have a duty to get their implementation right." He went on to outline progress made by the Government. The new clause was rejected after a vote.[201]

[201] PBC Deb 28 October 2021 c864

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