The Health and Care Bill

House of Lords, Committee of the whole House, 11 & 13 January 2022, consideration of clauses 1-34

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

The majority of the Health and Care Bill (the Bill) is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement (NHSE/I), and makes changes relating to public health, social care and patient safety.

We support the opportunity the Bill presents to design the right system architecture that will deliver sustainable, high-quality care for the future. However, we also believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be. NHS Providers has commented extensively on the Bill since its publication. Our briefings and written evidence to date can be found here and detailed background about ICSs can be found here. This briefing examines a number of amendments relating to Part 1 of the Bill.

Key points

- We welcome the direction of travel set out in the Bill which aims to drive closer collaboration and integration across the health and social care sector, helping trusts to build healthier communities.
- While we welcome the move to system working, more clarity on how different parts of the health system will work together is needed. Allowing different systems flexibility in how they frame their arrangements to meet local needs will also be key.
- We are concerned that provisions in the Bill open up the possibility of political interference in the health service by drawing significant powers of intervention and direction to the secretary of state.

Maintaining the clinical and operational independence of the NHS is vital to ensuring this complex system can work effectively. Similarly, we are concerned that new powers to allow the secretary of state to intervene in local service reconfigurations, as currently drafted, risk undermining local accountability in the NHS.

- We welcome measures in the Bill to place a new duty on the secretary of state setting out how workforce planning responsibilities are to be discharged but believe this duty needs to be strengthened.
- The Bill gives a new power to NHS England to restrict the spending of any individual NHS foundation trust. We wish to see important safeguards added to this proposal within the Bill to mirror what was agreed in NHS England's 2019 legislative proposals.
- We believe that the new provisions that will give the Care Quality Commission (CQC) scope to assess and rate systems need to be amended so that they do not impact on its ability to provide independent assurance – in particular, the secretary of state's powers to set priorities and objectives for the CQC's assessments of integrated care boards (ICBs) are concerning.

Clauses 1-34 and Schedules 1-5

Clause 5 (NHS England: wider effect of decisions)

Amendment

BARONESS THORNTON
LORD PATEL
BARONESS TYLER OF ENFIELD
LORD KAKKAR

Page 3, line 15, at end insert— "(d) health inequalities."

Member's explanatory statement

The amendment would extend the triple lock to specifically require NHS England to have regard to the likely effect of decisions in relation to the need to reduce health inequalities.

NHS Providers' view

A number of amendments addressing health inequalities have been tabled. Broadly, these introduce requirements for integrated care boards (ICBs), trusts and foundation trusts to both take account of health inequalities in their decision-making processes, and to ensure that efforts to address health inequalities are based on an up-to-date assessment of local needs.

We are supportive of a focus on health inequalities and explicit requirements to take account of health inequalities in the Bill, as this may help achieve a coherent approach to reducing disparities in health outcomes. However, legislation alone will not be sufficient to address the issue of health inequalities in the long term. Health inequalities are complex, multifaceted and will require the work of central government and wider system partners as well as trusts and ICBs to address.

A duty to 'take account of' health inequalities will not enable or drive progress if the wider determinants of health – such as the impact of housing needs, poverty, employment conditions and education – are not addressed in parallel. Success against the measures set out by NHS England will need to be measured with these wider factors in mind.

Amendments relating to the establishment and governance of ICBs

Clause 14 (Establishment of integrated care boards)

Amendment

LORD HUNT OF KINGS HEATH

Page 11, line 20, at end insert—
"14Z28A NHS Appointments Commission
(1) There is to be a body corporate known as the NHS Appointments Commission.
(2) The NHS Appointments Commission has the function of—
(a) appointing the Chair and ordinary members of integrated care boards;
(b) other duties as set out in regulations under subsection (3).
(3) The Secretary of State must by regulations provide for—
(a) the establishment and constitution of the board of the Commission;
(b) the financing of the Commission;
(c) the duties of the Commission.
(4) The Commission must prepare and submit an annual report of its activities to Parliament."

Member's explanatory statement

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

Schedule 2 (Integrated care boards: constitution etc)

Amendment

BARONESS THORNTON
LORD PATEL
BARONESS WALMSLEY

Page 137, line 30, at end insert—
"(d) at least one member nominated by the mental health trust or trusts that provide mental health services within the integrated care board's area;
(e) at least one member nominated by the Directors of Public Health that serve each local authority within the integrated care board's area;
(f) at least one member nominated jointly by any NHS trust, NHS foundation trust and local authority that provides social care services within the integrated care board's area;
(g) at least one member nominated by the trade unions representing the health and social care workforce that serves the integrated care board's area;
(h) at least one member appointed to represent the voice of patients and carers in the integrated care board's area."

Member's explanatory statement

This amendment adds to the list of requirements for membership of an ICB that must be included in ICB constitutions.

Amendment

LORD BRADLEY

Page 137, line 30, at end insert— "(d) at least one member nominated by an NHS Mental Health Trust."

NHS Providers' view

ICBs will be responsible for planning NHS services and allocating NHS funding. The Bill already provides for at least one trust, local authority and primary care partner member to sit on the ICB board, each of whom will be nominated and selected by relevant organisations. Beyond these seats around the table, it is important that all provider types – including mental health, community, ambulance, acute and specialist trusts – are involved in ICB decision-making to ensure a collaborative

approach to planning and delivering more integrated care within the resources available. We have called for a robust mechanism in each ICS for providers to feed into and influence ICB decision-making, and were pleased that the ICB model constitution, published in August 2021 by NHSE/I, states that each ICB constitution must set out how the ICB will include the full range of perspectives through its decision-making model and structures. More information on ICS structures can be found here.

We fully agree that ICB boards must consider the full range of a population's health and care needs, including mental health and public health. We would argue that this is best achieved through a manageable and effective unitary board. ICBs are to be governed by a unitary board and it is important to ensure any unitary board is of a manageable size to allow effective decision-making and oversight. Extending membership by default in this way risks ICB boards becoming unwieldy. In addition, ICBs will be unitary boards, where each board member acts for the collective good of the ICB, and takes collective responsibility for performance, rather than representing any particular sector or organisation. Although we fully support and expect ICB's to prioritise a focus on mental health, we are therefore not arguing for legal provisions mandating each segment of the provider sector – or wider perspectives such as public health – be represented on the board of the ICB.

Secondly, and importantly, a cornerstone of national ICS policy and the Bill itself has been that systems should have the flexibility to develop their ICS arrangements based on what makes sense in their local context; this proposed amendment risks undermining this ambition. For example, in some ICSs it might be best to bring in directors of public health at the non-statutory "place" tier, which will in some cases align with local authority footprints. In addition, the Bill already places a statutory duty on ICBs to obtain advice on prevention and public health, which we believe is sufficient to embed public health expertise in ICS decision-making. It would be more appropriate for NHS England to ensure ICBs are engaging with wider stakeholders appropriately and prioritising appropriately through national guidance and oversight frameworks. This would ensure ICBs take appropriate action, without undermining the welcome flexibility of the policy and legislative framework for ICSs.

We offer further commentary on proposed amendments to strengthen parity of esteem between mental health and physical health in this briefing with regard to proposed amendments to clauses 16, 20, 45, 59 and 67.

Amendment

LORD HUNT OF KINGS HEATH

Page 137, line 7, leave out "chair, with the approval of NHS England" and insert "integrated care board"

Member's explanatory statement

The amendment would provide that the Chief Executive is appointed by the integrated care board.

NHS Providers' view

We believe that the ICB should be fully involved in the appointment of the ICB chief executive to maintain the principle of collective responsibility, which is central to good governance. However, we do acknowledge there remains a role for the national body in making these appointments given their line of accountability.

Amendment

BARONESS MERRON

Page 137, line 7, at end insert—
"(1A) The constitution must provide for all members of the integrated care board and of the integrated care partnership to be consulted, and for any views expressed to be taken into account, before a chief executive is appointed."

Member's explanatory statement

This amendment would ensure the involvement of the integrated care board and the integrated care partnership in the appointment of the ICB chief executive.

NHS Providers' view

Although we agree that the ICB members should be involved in the appointment of the ICB chief executive, alongside NHS England's role, we do not believe that members of the integrated care partnership (ICP) should be consulted before the ICB chief executive is appointed. Given that the ICP will be established after the ICB, this would appear to create an impossible logistical issue. In addition,

this creates an unhelpful suggestion of hierarchy between the ICB and the ICP, which is not intended in the design of the two-part statutory ICS.

Schedule 3 (Conferral of primary care functions on integrated care boards etc)

Amendment

BARONESS THORNTON

Page 143, line 28, leave out "person" and insert "general practitioner, GP partnership or social enterprise providing primary medical services"

Member's explanatory statement

This amendment removes the possibility for further use of APMS contracts. It provides that ICBs must make contractual arrangements for the provision of primary medical services with any general practitioners, GP partnerships or social enterprises, rather than with 'any person'.

Amendment

Page 143, line 32, leave out "person" and insert "general practitioner, GP partnership or social enterprise providing primary medical services"

Member's explanatory statement

This amendment removes the possibility for further use of APMS contracts. It provides that ICBs must make contractual arrangements for the provision of primary medical services with any general practitioners, GP partnerships or social enterprises, rather than with 'any person'.

NHS Providers' view

These amendments would prohibit ICBs using Alternative Provider Medical Services (APMS) contracts when commissioning general practice. For example, it would reduce the organisations which could be contracted to deliver general practice by effectively ruling out independent sector or voluntary sector providers.

We do not support this amendment because it would limit ICBs' flexibility to meet local needs and support innovation, where necessary, in the delivery of primary care services. Prohibiting the use of

APMS contracts, if ostensibly intended to reduce independent sector provision, also risks making it more difficult for voluntary and community sector providers to deliver elements of primary care services.

Amendment

LORD HUNT OF KINGS HEATH

Page 22, line 30, at end insert—

"(aa) the relevant local medical, dental, pharmaceutical and optical committees, and"

Member's explanatory statement

This amendment would ensure that in preparing their annual strategic forward plan, the Integrated Care Board and its partner NHS trusts and NHS foundation trusts would need to consult the relevant primary care Local Representative Committees and publish an explanation of how they took account of those views when publishing their plan.

Amendment

Page 22, line 31, at beginning insert "including through any relevant Healthwatch,"

Member's explanatory statement

This is to ensure that in any consultation on the forward plan, Healthwatch should have a pivotal role in relation to consulting local people.

NHS Providers' view

ICBs are responsible for developing a five-year plan for NHS services, refreshed annually. The Bill in its current form states that the five-year plan is to be produced in consultation with local system partners, particularly trusts and foundation trusts – and will be informed by consultation with other local stakeholder such as health and wellbeing boards. Given this broad expectation of engagement, it is not clear that there is a strong rationale for placing a legal responsibility on ICBs to consult specific professional groups.

The Bill places requirements on ICBs to involve local people in the planning of health and care services. While local Healthwatch organisations can play a valuable role in that process, and national guidance positions them as doing so, there are several approaches ICBs could use to involve local people. In addition, there is an existing duty in the Bill for ICPs to involve local Healthwatch organisations when preparing the integrated care strategy for the ICS, which ICBs will need to have regard to when developing their five-year plans. As such, it is not necessary to direct ICBs to consult local Healthwatch organisations in legislation.

Amendment

BARONESS WHEELER

Page 31, line 43, at end insert—
"(3) The Secretary of State must by regulations make provision for a procedure to be followed should an integrated care partnership believe that an integrated care board has failed in its duty under this section."

Member's explanatory statement

This amendment would require the Secretary of State to establish a procedure for the resolution of any dispute between an integrated care partnership and an integrated care board, concerning the implementation of a strategy produced by the integrated care partnership.

NHS Providers view

In their statutory form, ICSs will be comprised of the ICB (responsible for NHS funding and planning) and the ICP (responsible for a wider plan to meet the health, social care and public health needs of the population). These two parts of the local health and care system will need to work together to ensure they collectively bring key partners together to align strategies, improve population health outcomes and tackle health inequalities. It would be unhelpful to introduce a dynamic of hierarchy or performance management to this relationship or to change the formal accountabilities of the NHS. We believe there is a sufficient emphasis on the ICB needing to "have regard to" the integrated care strategy when developing its five-year health plan, and therefore do not support this amendment.

Amendment

LORD HUNT OF KINGS HEATH
LORD CRISP

Page 29, line 19, at end insert—
"(ba) members appointed by each of the local medical, dental, pharmaceutical and optical Committees, and"

Member's explanatory statement

This amendment would ensure that primary care professions would have mandated roles within Integrated Care Partnerships with a member appointed by each of the practitioner committees.

Amendment

LORD HUNT OF KINGS HEATH
BARONESS TYLER OF ENFIELD
LORD PATEL

Page 29, line 20, at end insert—

"(2A) An integrated care partnership shall include a representative of Healthwatch, jointly nominated from the local Healthwatch whose areas coincide with, or include the whole or any part of, the integrated care system, and approved by Healthwatch England."

Member's explanatory statement

The amendment ensures that ICPs have a Healthwatch nominee in membership.

NHS Providers' view

The Bill states that ICPs will lead the development of an integrated care strategy for their area. Currently the Bill takes a permissive approach to the membership of ICPs, specifying only that the relevant ICB and local authorities must be involved in establishing the ICP, and wider membership will be determined locally. This amendment, conversely, would begin to mandate certain perspectives.

NHS Providers does not support these amendments as they cut across the flexible legislative framework that national bodies, and the wider sector, have rightly sought to establish for ICSs,

recognising that organisational configurations vary around the country and ICP membership arrangements will need to be tailored for local circumstances. NHSE/I guidance is clear that involving a wide range of partners – including the Voluntary Community and Social Enterprise (VCSE) sector and local communities – in ICPs is essential, and systems must have the flexibility to decide how to use different mechanisms to ensure all these views are heard, including ICP membership, committees and other forums.

After Clause 27

Amendment

LORD HUNT OF KINGS HEATH
BARONESS TYLER OF ENFIELD

Insert the following new Clause—

"Place based integrated care and Primary Care Commissioning Boards
(1) Each place based integrated care board is to be established by regulations made by the Secretary of State for an area within an integrated care board.
(2) An order establishing a place based integrated care board must provide for the constitution of the board.
(3) Before making, varying or revoking an order under this section, the Secretary of State must consult—
(a) the integrated care board in which the place based integrated care committee is intended to operate;
(b) the relevant local authority or local authorities;
(c) the integrated care partnership in which the place based integrated care committee is intended to operate;
(d) the local Healthwatch organisations whose areas coincide with or fall wholly or partly within the proposed area of the place based integrated care board.
(4) Members of the public living within the proposed area of the place based integrated care board.
(5) The place based integrated care board may arrange under a scheme of delegation from the integrated care board for the provision of such services or facilities it considers appropriate for the purposes of the health service that relate to securing the improvement—
(a) in the physical and mental health of the people for whom it has responsibility, or
(b) in the prevention, diagnosis and treatment in these people.

(6) In imposing financial requirements on integrated care boards under Section 223GB of the National Health Service Act 2006, NHS England may give
additional directions in respect of placed based integrated care committees.
(7) Integrated care boards may give place based integrated care board directions as to any of the functions to which it has given delegated functions.
(8) The Schedule to the Public Bodies (Admission to Meetings) Act 1960 (bodies to which that Act applies) shall be amended as follows.
(9) After paragraph 1(k), there shall be added the following sub-paragraph— "(l) Place Based Integrated Care Boards.""

Member's explanatory statement

It's likely that ICBs will set up place based entities which may take many of the key commissioning decisions at the local/Constituency level. This amendment puts place based integrated boards on a statutory basis and subject to Parliamentary oversight and meeting in public.

NHS Providers' view

National ICS policy and the ambitions underpinning the Bill make clear that collaboration at place (smaller sub-geographies within ICSs, often based on local authority footprints) will be a key aspect of system working. Given the significant size of some ICSs, there will likely be some planning of NHS services at place level, including more joined up health and care services. This amendment seeks to provide a greater degree of formality around planning at place by providing a statutory basis for place-based commissioning boards.

We do not support this amendment to put place-based partnerships on a statutory footing.
Firstly, this goes against the government's ambition to create a permissive framework based on the principle of subsidiarity to allow local areas to build on what is working well at ICS and place level, rather than imposing models or a mandatory approach. While some ICSs are already exploring what planning functions would make sense to occur at place level, and which financial resources will in time flow from ICBs to places to enable that, these decisions need to be driven locally based on what works for local circumstances in response to local population needs.

Secondly, while integrated health and social care commissioning at place level may be a helpful long-term ambition (and a goal some local systems are already successfully voluntarily pursuing), forcing two different systems together at pace, without altering the underlying financial flows, infrastructure and accountabilities in primary legislation, carries several risks, including: creating a system that is not

fit for purpose; crunching together two different, over-stretched funding systems; negatively impacting patient care; further disenfranchising already stretched staff; and critically, setting back delivery of the sector and government's shared aim to improve integration.

The mechanisms for health and social care integration at place level exist already (such as joint commissioning, joint provision and multidisciplinary teams). The success of these varied approaches depends on local behaviours, relationships and leadership, rather than mandatory commissioning structures.

Amendment

LORD HUNT OF KINGS HEATH
BARONESS WALMSLEY

Insert the following new Clause—
"Provider Network Boards
(1) A Provider Network Board has the function of arranging for the provision of services delegated to it by integrated care boards.
(2) Each place based Provider Network Board is to be established by regulations made by the Secretary of State for an area within an integrated care board.
(3) An order establishing a Provider Network Board must provide for the constitution of the board.
(4) Before making, varying or revoking an order under this section, the Secretary of State must consult—
(a) the integrated care board in which the Provider Network Board is intended to operate;
(b) the relevant local authority or local authorities;
(c) the integrated care partnership in which the Provider Network Board is intended to operate;
(d) the local Healthwatch organisations whose areas coincide with or fall wholly or partly within the proposed area of the place based integrated care board;
(e) members of the public living within the proposed area of the place based integrated care board.
(5) The Provider Network Board may arrange under a scheme of delegation from the integrated care board for the provision of such services or facilities it considers appropriate for the purposes of the health service that relate to securing the improvement—
(a) in the physical and mental health of the people for whom it has responsibility, or
(b) in the prevention, diagnosis and treatment in these people.
(6) In imposing financial requirements on integrated care boards under Section 223GB of the National Health Act 2006, NHS England may give additional directions in respect of Provider Network Boards.

(7) Integrated care boards may give Provider Network Boards such directions as to any of the functions to which it has given delegated functions.
(8) The Schedule to the Public Bodies (Admission to Meetings) Act 1960 (bodies to which that Act applies) shall be amended as follows.
(9) After paragraph 1(k), there shall be added the following sub-paragraph—
"(l) Provider Network Boards.""

Member's explanatory statement

Provider networks are likely to exercise considerable influence under the new arrangements being brought in under this Bill. The amendment puts provider Networks on a statutory basis and subject to Parliamentary oversight and a requirement to meet in public.

NHS Providers' view

Collaboration between trusts across an ICS or several ICSs is an important element of delivering the benefits of system working, including supporting services to be more resilient and developing new ways of working aimed at helping those experiencing health inequalities. The pandemic response has reinforced the value of trusts working together to tackle shared challenges, with the benefits of sharing equipment, capacity and staff coming to the fore like never before. This amendment seeks to give a greater degree of formality to provider collaboration by placing 'provider network boards' on a statutory basis.

While NHS Providers supports efforts to promote collaboration between provider organisations, we do not support this amendment. Firstly, collaboration between providers is likely to take a number of forms based on local circumstances and needs – with varying degrees of formality required. Local systems must have the flexibility to determine what these arrangements look like and ensure governance arrangements are proportionate to the programmes being delivered. A blanket approach to placing provider collaboratives on a statutory basis would therefore be inappropriate.

Secondly, establishing collaboratives as statutory entities risks creating confused accountability between ICBs, trusts (which retain their existing statutory responsibilities) and provider collaboratives. Trust leaders and their partners are already coping with significant transformative change, as set out in the current wording of the Bill in a context of unprecedented operational pressure. This amendment is unnecessary and would destabilise the system at a critical time.

Thirdly, collaboration between providers is likely to occur along more than one axis. These arrangements for mutual aid and service collaboration need to be maintained with sufficient flexibility to respond to changing circumstances and changing patient need – for example, to deliver, and refine, "horizontal" collaboration among trusts of a similar type in an ICS, "vertical" collaboration within places across primary/secondary/social care and more specialised clinical networks across several ICSs. There is real a risk that codifying and calcifying these arrangements in statutory form would add multiple unwelcome and potentially confusing additional tiers of bureaucracy into the system and make the NHS much less responsive to changing needs

ICBs' role in identifying and meeting the needs of children and young people

A number of amendments have been tabled relating to the role of ICBs in meeting the needs of children and young people. For the purpose of this briefing, we have grouped a number of amendments and have commented on these collectively.

Clause 20 - (General functions)

Amendment

BARONESS TYLER OF ENFIELD
BARONESS FINLAY OF LLANDAFF
THE LORD BISHOP OF LONDON

Page 25, line 31, at end insert—
"(3A) In conducting a performance assessment, NHS England must assess how well the integrated care board has identified and met the needs of children and young people aged 0-25.
(3B) For the purposes of carrying out the assessment in subsection (3A), NHS England must publish a national accountability framework for children and young people."

Member's explanatory statement

This amendment would require NHS England to assess how well an integrated care board has met children and young people's needs in relation to a national accountability framework they have responsibility for publishing.

Amendment

BARONESS WALMSLEY

Page 25, line 44, at end insert—

"14Z57A Report on child impact assessment

(1) Each integrated care board must review and prepare an annual report on the impact of the changes for children and young people resulting from the Health and Care Act 2022 within two years of the passing of that Act.

(2) The Secretary of State must prepare and publish an annual report that compares all integrated care boards' assessments of the impact on children and young people and lay the report before Parliament.

(3) A Minister of the Crown must, not later than two months after the report has been laid before Parliament, make arrangements for—

(a) a motion in neutral terms, to the effect that the House of Commons has considered the matter of the report mentioned in subsection (2), to be moved in that House by a Minister of the Crown, and

(b) a motion for the House of Lords to take note of the report to be moved in that House by a Minister of the Crown."

Member's explanatory statement

This amendment would require Integrated Care Boards to prepare an annual report on the impact of the changes for children and young people introduced by this Act, and for the Government to organise a debate on the impact on children and young people in Parliament.

Clause 21 (Integrated care partnerships and strategies)

Amendment

BARONESS TYLER OF ENFIELD

BARONESS FINLAY OF LLANDAFF

Page 29, line 30, at end insert—

"(1A) In preparing a strategy under this section, an integrated care partnership must include specific consideration of how it will meet the needs of children and young people aged 0-25."

Member's explanatory statement

This amendment would require an integrated care partnership to specifically consider the needs of babies, children and young people when developing its strategy.

After Clause 40

Amendment

BARONESS MEACHER
BARONESS TYLER OF ENFIELD
BARONESS WALMSLEY

Insert the following new Clause—
"Regulations and statutory guidance on babies, children and young people
(1) The Secretary of State must publish regulations on how integrated care systems must meet the needs of babies, children and young people aged 0 to 25.
(2) The Secretary of State must publish guidance on how integrated care systems should meet their obligations under subsection (1).
(3) The Secretary of State must lay a copy of the guidance before each House of Parliament.
(4) Integrated care systems must act in accordance with the guidance in subsection (2)."

Member's explanatory statement

This Clause would require the Secretary of State to lay regulations and publish guidance on how integrated care systems should meet the needs of babies, children and young people aged 0-25. This would also require integrated care systems to act in accordance with guidance.

NHS Providers' view

It will be crucial for ICSs to meet all population health needs, including those of children and young people. Trust leaders are increasingly concerned about the impacts of the pandemic on children's mental and physical health, including safeguarding issues and delays in accessing support. Given that the ICB will be responsible for developing a plan to meet the health needs of the entire system population (of all ages), we do not believe that there should be a specific requirement in statute to place a separate focus on sub-populations such as children and young people. However, we do support NHS England emphasising the importance of a collective approach to children's and young people's services in future guidance for ICBs/ICPs.

Amendments tabled relating to parity of esteem between mental and physical health

A number of amendments have been tabled relating to parity of esteem between mental and physical health. For the purpose of this briefing, we have grouped a number of amendments and have commented on these collectively.

Clause 16 (Commissioning hospital and other health services)

Amendment

BARONESS WALMSLEY
BARONESS TYLER OF ENFIELD

Page 13, line 43, after "prevention of" insert "physical or mental"

Member's explanatory statement

This amendment ensures that equal weight is given to physical and mental illness in the provision of services or facilities.

Amendment

Page 13, line 44, after "from" insert "physical or mental"

Member's explanatory statement

This amendment ensures that equal weight is given to physical and mental illness in the provision of services or facilities.

Clause 20 (General functions)

Amendment

BARONESS WALMSLEY
BARONESS TYLER OF ENFIELD

Page 17, line 9, after "of" insert "physical and mental"

Member's explanatory statement

This amendment is to ensure parity of esteem between physical and mental health.

Amendment

BARONESS HOLLINS
BARONESS TYLER OF ENFIELD

Page 18, line 18, after the first "the" insert "physical and mental"

Member's explanatory statement

This amendment will require Integrated Care Boards to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness replicating the parity of esteem duty as introduced in the Health and Social Care Act 2012.

Amendment

Page 18, line 23, after the first "of" insert "physical and mental"

Member's explanatory statement

This amendment will require Integrated Care Boards to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness replicating the parity of esteem duty as introduced in the Health and Social Care Act 2012

Amendment

LORD PATEL
BARONESS TYLER OF ENFIELD
LORD KAKKAR

Page 16, line 36, at end insert—"(c) implement systems to identify and monitor inequalities in physical and mental health between different groups of people within the population of its area."

Clause 45 (NHS trusts: wider effect of decisions)

Amendment

BARONESS HOLLINS
BARONESS TYLER OF ENFIELD

Page 49, line 34, after the first "the" insert "physical and mental"

Member's explanatory statement

This amendment will require NHS Trusts to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness, replicating the parity of esteem duty introduced in the Health and Social Care Act 2012.

Amendment

Page 50, line 2, after the first "of" insert "physical and mental"

Member's explanatory statement

This amendment will require NHS Trusts to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness, replicating the parity of esteem duty introduced in the Health and Social Care Act 2012.

Clause 59 (NHS foundation trusts: wider effect of decisions)

Amendment

BARONESS HOLLINS
BARONESS TYLER OF ENFIELD

Page 55, line 28, after the first "the" insert "physical and mental"

Member's explanatory statement

This amendment will require NHS foundation trusts to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment

of both physical and mental illness, replicating the parity of esteem duty introduced in the Health and Social Care Act 2012.

Clause 67 (Wider effect of decisions: licensing of health care providers)

Amendment

BARONESS HOLLINS
BARONESS TYLER OF ENFIELD

Page 61, line 32, after the first "the" insert "physical and mental"

Member's explanatory statement

This amendment will require decisions on licensing of health care to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness, replicating the parity of esteem duty introduced in the Health and Social Care Act 2012.

Amendment

Page 61, line 38, after the first "of" insert "physical and mental"

Member's explanatory statement

This amendment will require decisions on licensing of health care to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness, replicating the parity of esteem duty introduced in the Health and Social Care Act 2012.

NHS Providers view

Despite welcome investment and focus in recent years on dismantling the stigma of mental ill health and achieve equity between the treatment of mental and physical health, and the best efforts of those working in and leading the sector, the healthcare system is still operating in the context of a 'care deficit' where not all those that need help and treatment will seek or be able to access support. There are now 1.6 million people waiting to access mental health services and prevalence data suggests there are many millions more who would benefit from services if they were able to meet the thresholds to access them. There are also continuing instances of mental health services not being

prioritised. One such example is the under-prioritisation of investment in the mental health estate, which is having a real impact on trusts' ability to ensure a safe and therapeutic environment. The Prime Minister's announcement on investment in new hospitals almost entirely overlooked the needs of mental health trusts.

The need to replicate the parity of esteem duty is even more important now given increasing levels of, and often more complex, demand for mental health services, at a time when there is growing unmet need across multiple fronts in health and care and systems face difficult choices around the allocation of resources. The full mental health impact of the pandemic is still emerging, but mental health trust leaders are reporting extraordinary pressures. In particular, a high proportion of children and young people not previously known to services are coming forward for treatment, and they are more unwell, with more complex problems, than the patients previously generally seen by these services.

We therefore welcome the recognition of the important role that NHS England, ICBs and NHS trusts and foundation trusts will each have in advancing parity of esteem between mental and physical health. It will be important for any amendments to the Bill that require the prioritisation of both physical and mental health to be made at each of these levels – trusts' ability to prioritise both physical and mental health is impacted by the extent to which ICBs and NHS England do. We would also stress that each level's ability to meet this requirement is ultimately reliant on the government prioritising both physical and mental health.

We can also see the value in the secretary of state being required to make an annual statement on how the funding received by mental health services has contributed to the improvement of mental health and the prevention, diagnosis and treatment of mental illness. However, it is important to recognise that this would require further progress on data collection and data quality to give a better understanding of mental health activity, access and outcomes to be truly meaningful and add value.