Written evidence submitted by National Voices to the House of Commons Public Bill Committee on the Health Bill 2026

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About National Voices

National Voices is the largest coalition of health and care charities in England. It works to ensure that people's experiences, needs and priorities shape health and social care policy, commissioning and delivery, with particular attention to people facing poorer access, experience or outcomes.

Our written evidence focuses on the patient voice provisions in the Health Bill, in particular Clauses 64 and 65 and Schedules 9 and 10.

Introduction

1. National Voices submits this evidence on the patient voice provisions in the Health Bill. Our preferred position – echoing the Health Foundation and the Nuffield Trust – is that the Committee should remove Clause 64 and Clause 65, and the associated Schedules 9 and 10, so that Healthwatch England and Local Healthwatch organisations are retained (The Health Foundation, 2026; Nuffield Trust, 2026).
2. If the Committee decides to retain Clauses 64 and 65, National Voices supports Amendments 1-11 set out in the appendix to this submission. Those amendments are safeguards. They seek to retain, on the face of the Bill, the national and local functions that would otherwise be weakened or lost if Healthwatch England and Local Healthwatch are abolished.
3. The Government's case is that abolition will simplify the patient safety and feedback system, bring patient and user feedback closer to strategic decision-making, and place clearer responsibility on DHSC, ICBs and local authorities. The impact assessment states that the current system is complex, that routes for feedback are not always clear, and that patient voice lacks influence on commissioning and policy-making (Department of Health and Social Care, 2026). National Voices recognises those problems. They do not, by themselves, justify the removal of the only statutory national and local infrastructure dedicated to independent patient, carer and service-user voice across health and social care.
4. DHSC's impact assessment describes Local Healthwatch functions as obtaining views, making reports and recommendations, promoting and supporting public involvement, providing information and advice, making views known to Healthwatch England, and making recommendations to Healthwatch England about possible CQC reviews or investigations. It describes Healthwatch England's functions as leadership, guidance and support to Local Healthwatch; escalation of concerns to CQC; and advice to the Secretary of

State, NHS England and local authorities, with written response duties for bodies receiving that advice (Department of Health and Social Care, 2026).

5. The Bill as written does not replace that full set of functions. It places duties on ICBs and local authorities to make arrangements to obtain views about services and to consider those views when exercising relevant functions. That is narrower than the current model. It does not, by itself, preserve an independent route for unsolicited feedback, signposting, outreach, cross-system intelligence, public reporting, escalation or thematic learning (Department of Health and Social Care, 2026; Picker, 2026). Healthwatch England's supplementary evidence identifies the same functions as matters for scrutiny, including locally determined priorities, Enter and View powers, information and signposting, escalation from local to national level, transparent reporting and a joined-up health and social care remit (Healthwatch England, 2026).
6. The Committee heard evidence from Jacob Lant, Chief Executive of National Voices, that the proposed abolition of Healthwatch is not a "lift and shift". He identified functions at risk, including signposting, unsolicited feedback, outreach into communities, and patient and community voice on Health and Wellbeing Boards. He also raised the risk that ICBs will be expected to take on local patient voice functions without the funding currently attached to Local Healthwatch arrangements, leaving fewer resources for listening to patients and communities (Department of Health and Social Care, 2026; Public Bill Committee, 2026).
7. The King's Fund's research on the future of patient voice found that Healthwatch's independence has made it credible with communities, allowed scrutiny of issues the system may overlook, and supported trusted advice and guidance. It also found that the Healthwatch model combined local reach with national influence, gathered unsolicited insight not always captured elsewhere, and helped place issues such as NHS administration failures, GP access and dentistry higher on the national policy agenda (Morris et al., 2026). Healthwatch England's supplementary evidence gives examples of local insight leading to national action, including on corridor care, NHS dentistry, waiting list inequalities and accessible communication in cancer care (Healthwatch England, 2026). CQC has also said that current arrangements provide independent feedback and qualitative data that help detect safety issues early, particularly for disadvantaged groups less likely to use formal feedback routes (Care Quality Commission, 2026). Picker has argued that the Bill does not yet give enough detail on how Healthwatch's functions will be safeguarded in a new structure (Picker, 2026).

8. DHSC's impact assessment also identifies risks from abolition, including loss of independence, loss of institutional knowledge, delivery risk for ICBs, duplication during transition, and loss of a holistic view across health and social care. It notes that the exact approach to implementation remains uncertain because it depends on future policy decisions, including the design of the new DHSC patient experience directorate and guidance to ICBs and local authorities (Department of Health and Social Care, 2026). CQC has said that abolition has implications for people's safety that will need careful management through transition (Care Quality Commission, 2026).
9. National Voices accepts that patient voice arrangements should be judged by their effect. The question is whether the Bill will require the new arrangements to hear from patients, carers and service users; show who has and has not been heard; explain how feedback has been used; report what changed; and escalate serious concerns. Jacob Lant's evidence put this test in practical terms: what was heard, who was missed, how feedback was interpreted, what changed, and whether that change improved patient experience (Public Bill Committee, 2026). National Voices' Second Reading briefing set out the same tests as transparency, accountability, equity and resourcing (National Voices, 2026).
10. If Parliament proceeds with abolition, Amendments 1-11 provide a coherent statutory package. Amendments 1 and 2 create national infrastructure. Amendments 3, 5, 6, 8, 9 and 11 create local duties to obtain, analyse, publish and respond to views, and to report what action has followed. Amendments 4, 7 and 10 create equity duties, requiring ICBs and local authorities to take reasonable steps to hear from people and communities likely to experience health inequalities.

National infrastructure: Amendments 1 and 2

11. If Parliament retains Clause 64, it should not leave the national patient voice function to policy design after Royal Assent. The Bill would abolish Healthwatch England. The Government's impact assessment says Healthwatch England's statutory functions would be repealed and responsibility placed on the Secretary of State. The same assessment says the exact approach to implementation remains uncertain (Department of Health and Social Care, 2026). That is not a secure basis for replacing a statutory national patient voice body.
12. The Government's policy objective is to feature patient and user feedback more centrally in strategic and decision-making functions (Department of

Health and Social Care, 2026). Amendments 1 and 2 would help give that objective legal form. They would place national patient experience infrastructure on the face of the Bill, rather than relying only on guidance, internal departmental design or ministerial assurance.

13. Amendment 1 would require the Secretary of State to secure arrangements for a national patient experience and feedback function in relation to health services and social care services in England. That function would gather, analyse and publish evidence about the experiences of patients, carers and service users; identify recurring concerns; identify inequalities in access, experience and outcomes; identify groups whose views have not been adequately captured; make recommendations for improvement; and provide a route for local concerns to be escalated to national bodies.

14. Amendment 1 would also require annual reporting to Parliament. The report would cover principal findings, recurring concerns, inequalities, groups whose views have not been adequately captured, recommendations made, responses received, action taken, cases where no sufficient response has been received, and the impact of action taken in response to previous recommendations. That would allow Parliament to test whether the new model is moving from listening to influence on policy, commissioning and improvement.

15. Amendment 2 would place the National Patient Experience Director on a statutory footing in relation to health services and social care services in England. The Director's functions would include gathering, analysing and publishing experience evidence; identifying themes and learning from complaints, concerns and feedback; reporting on inequalities; reviewing the effectiveness of ICB and local authority arrangements; advising the Secretary of State, ICBs, local authorities and the CQC; and making recommendations.

16. Amendment 2 would also give the Director an advisory group including patients and service users, carers, voluntary, community and social enterprise organisations, and people with experience of health inequalities. Picker has proposed that the Bill should include a statutory reporting duty for the Secretary of State and a duty to work with an independent external advisory group on patient experience (Picker, 2026). The King's Fund found that the proposed Director role has potential only if it carries sufficient authority and the ability to hold others to account across government and the health and care system (Morris et al., 2026).

17. Amendments 1 and 2 (see: Appendix 1) should be read together. Amendment 1 secures the national function. Amendment 2 secures named leadership, advice, review and an advisory structure. Together, they would help retain the

national capabilities most at risk from abolition of Healthwatch England: collection and analysis, publication, thematic learning, escalation, recommendations, responses, Parliamentary reporting and system leadership.

Local duties: Amendments 3, 5, 6, 8, 9 and 11

18. If Parliament retains Clause 65 and Schedule 10, the Bill must give ICBs and local authorities clear local duties that go beyond collecting views. The Bill would abolish Local Healthwatch organisations and split their functions across ICBs, local authorities' public health functions and local authorities' social care functions. That creates a risk that local patient and service-user voice becomes narrower, less visible and less able to see across service boundaries.

19. Amendments 3, 6 and 9 address the core weakness in the Bill's local duties. They replace a duty to make "such arrangements as [the body] considers appropriate to obtain" views with a duty to make "effective, accessible and proportionate arrangements for obtaining, analysing, publishing and responding to" those views. This wording applies across ICBs, public health services and social care services.

20. This change is needed because "obtain and consider" is too thin a statutory test for the functions replacing Local Healthwatch. DHSC's impact assessment describes Local Healthwatch functions as obtaining views, making reports and recommendations, promoting and supporting public involvement, providing information and advice to the public, making views known to Healthwatch England, and making recommendations to Healthwatch England about possible CQC reviews or investigations (Department of Health and Social Care, 2026). Healthwatch England's supplementary evidence also asks how current functions will be preserved or replaced, including local priorities shaped by communities, Enter and View, information and signposting, national patient voice, escalation, transparency and reporting (Healthwatch England, 2026). A replacement duty should therefore cover analysis, publication and response, not only collection.

21. Amendments 5, 8 and 11 add annual publication duties across ICBs, public health services and social care. Each relevant body would have to publish a summary of views obtained; information about the people and communities from whom views were obtained and, so far as reasonably practicable, those from whom views were not obtained; an explanation of how those views were considered; a statement of action taken or proposed, or reasons for taking no action; an assessment of the impact of action taken; and a statement of

concerns escalated to the Secretary of State, the CQC or other relevant bodies.

22. These reporting duties are the mechanism by which patients, carers, service users, Parliament and local communities can see whether the new arrangements work. Without them, there is a risk that an ICB or local authority could gather views, consider them internally and take no visible action. The Bill would then have brought patient voice closer to statutory bodies without making those bodies accountable for what they did with it.

23. The reporting duties also answer a weakness identified by the Government's impact assessment. DHSC says the intended benefit of abolition is that patient and user voice will shape commissioning and delivery of services, and that accountability for listening will increase (Department of Health and Social Care, 2026). Amendments 5, 8 and 11 would require bodies to show how feedback informed action, or their reasons for why no action followed.

24. Amendments 5, 8 and 11 would also require ICBs and local authorities to maintain arrangements for sharing significant patient, carer and service-user concerns with relevant oversight bodies in a timely manner. Serious concerns should not sit only with the body responsible for the service, commissioning decision or pathway giving rise to them.

25. The need for escalation is particularly clear where experiences cut across health and social care. DHSC's impact assessment recognises that Local Healthwatch currently fulfils functions relating to both social care and health care, and that splitting responsibilities between ICBs and local authorities could risk losing "a holistic view across the whole person experience of health and social care" (Department of Health and Social Care, 2026). Jacob Lant made the same point in oral evidence, using hospital discharge as an example of poor experience that often sits between services rather than within a single organisation (Public Bill Committee, 2026). Healthwatch England's supplementary evidence asks how the new model will keep a joined-up view across NHS and social care and provide a clear way to escalate local concerns nationally (Healthwatch England, 2026).

26. Picker also identifies an asymmetry in the Bill. ICBs are expected to report annually to DHSC on feedback collection and what that feedback has informed, while local authorities would report only on request from the Secretary of State. Picker argues that local authorities should also report annually, so that ICBs and local authorities are on the same footing in relation to patient and service-user voice (Picker, 2026). Amendments 8 and 11 would provide that equal reporting duty for public health and social care.

27. The local duty package is therefore a minimum replacement for core Local Healthwatch functions if abolition proceeds. It would not reproduce Local Healthwatch in full. It would, however, require the bodies taking on these functions to hear from people, analyse what they hear, publish it, respond to it, show what action followed, explain where no action is taken, and escalate significant concerns.

Equity duties: Amendments 4, 7 and 10

28. If Parliament retains Clause 65 and Schedule 10, the Bill must require ICBs and local authorities to reach people and communities who are least likely to be heard through standard engagement routes. A general duty to obtain views may reproduce the voices already easiest for statutory bodies to reach.

29. Amendments 4, 7 and 10 would require ICBs and local authorities, when making arrangements to obtain views, to take reasonable steps to obtain the views of people and communities likely to experience health inequalities. The amendments name barriers linked to disability, deprivation, social exclusion, language, digital exclusion and discrimination. They apply across ICB functions, public health services and social care services.

30. The amendments would also require ICBs and local authorities to secure appropriate arrangements where people or communities are unlikely or unable to engage directly. Those arrangements may include working through voluntary, community and social enterprise organisations with relevant expertise or trusted relationships. This recognises that trust, access and participation are not created by opening a consultation portal or issuing a survey.

31. The Government's impact assessment identifies the relevant risk. It states that people with protected characteristics may experience differential impacts. It gives examples of disabled people and trans people facing barriers to engaging directly with health and social care providers. It also notes that women affected by poor maternity care and people who have experienced discrimination because of sexual orientation may not want to, or feel able to, provide feedback directly to the providers where they experienced poor treatment (Department of Health and Social Care, 2026).

32. The same impact assessment says DHSC will support ICBs and local authorities with guidance, including support to design inclusive feedback mechanisms for hard-to-reach groups (Department of Health and Social Care, 2026). Guidance is useful, but it is not a substitute for a statutory duty. The Bill abolishes

existing statutory local voice arrangements. It should set the minimum legal expectation for inclusive replacement arrangements on the face of the Bill.

33. The King's Fund found that Healthwatch's independence helped it build credibility with communities and allowed it to scrutinise issues the health and care system might overlook. It also found that local Healthwatch organisations had built effective relationships with communities, including people less likely or less able to put their views forward, and that targeted local work helped address biases in unsolicited feedback (Morris et al., 2026). National Voices' Second Reading briefing made the same point: Healthwatch's value has included trusted links with communities less likely to engage directly with NHS institutions, including disabled people, ethnic minorities and inclusion health groups such as people experiencing homelessness (National Voices, 2026).

34. Inclusion health charities have similarly argued that there are no statutory duties or provisions in the Bill to ensure that the experiences of "seldom heard" groups inform service design and delivery. They recommend that ICBs should make documented arrangements to engage inclusion health populations, use outreach methods with local VCSE expertise, show that engagement has taken place through reporting, and support paid participation for people with relevant experience (Crisis, Groundswell, Homeless Link, Pathway and St Mungo's, 2026).

35. The equity duties therefore protect one of the functions most at risk if Local Healthwatch is abolished. Without them, the new system could hear from more people while still missing those most likely to have poor access, poor experience and poor outcomes. That would not meet the Government's aim of making patient and user feedback more central to decision-making.

36. Amendments 4, 7 and 10 do not prescribe one model for every place. They require reasonable steps and appropriate arrangements. That leaves room for local design, while placing a clear duty on ICBs and local authorities to plan for participation by people who may not trust, access or use standard feedback routes.

Why statutory provision is required

37. Clauses 64 and 65, and Schedules 9 and 10, would repeal or remove the present statutory arrangements for Healthwatch England and Local Healthwatch. It is not enough to replace those arrangements through guidance, internal departmental design or future policy decisions.

38. The Government's impact assessment states that the preferred option is to abolish Healthwatch England and Local Healthwatch, repeal Healthwatch England's statutory functions, and confer or place responsibilities elsewhere. It also states that the exact approach to implementation remains uncertain because it depends on future policy decisions, including the design of the patient experience directorate in DHSC and guidance for ICBs and local authorities (Department of Health and Social Care, 2026).

39. Parliament is therefore being asked to remove an existing statutory patient voice infrastructure before the replacement model is set out in equivalent statutory detail. Picker makes the same point in relation to Clause 64: the clause abolishes Healthwatch England, but does not itself transfer functions to the Secretary of State or set out the proposed Directorate of Patient Experience in DHSC (Picker, 2026).

40. Guidance can help public bodies meet their duties. It cannot supply the duties that Parliament has chosen not to enact. If duties to publish, respond, report, escalate and reach under-represented groups are left to guidance, they will be easier to alter, narrow or defer. They will also be harder for Parliament, local communities and patients to test.

41. The need for statutory safeguards is greater because the bodies receiving these functions will also be under operational and financial pressure. DHSC's impact assessment identifies delivery risks for ICBs where they currently rely on Local Healthwatch outputs, possible loss of institutional knowledge, transition risks and possible loss of a holistic view across health and social care (Department of Health and Social Care, 2026). CQC has said that abolition has implications for people's safety that will need careful management through transition, and that it will need to redefine how it receives feedback previously received from local Healthwatch bodies and ICBs (Care Quality Commission, 2026). These risks strengthen the case for minimum statutory expectations.

42. The King's Fund's research points to the same conclusion. It found that whatever replaces Healthwatch must build on the conditions that allowed it to have a positive impact: a voice independent of government and services; capacity to gather unsolicited, varied and rich community insight, including from seldom-heard groups; and a geographical scale that supports local insight and national or system-level influence. It also found that, where full structural independence cannot be secured, it must be offset by transparency and accountability measures (Morris et al., 2026). The Health Foundation has said that any replacement must retain some degree of independence from the NHS and government, have enough infrastructure to gather local data and influence national decisions, and be resourced to do so effectively (The Health Foundation, 2026).

43. National Voices therefore asks the Committee to put the replacement tests on the face of the Bill. If Healthwatch is abolished, the new arrangements should be required to gather and analyse patient, carer and service-user experience; publish what is heard; show who has and has not been heard; respond to feedback; show action taken or proposed; give reasons where no action is taken; escalate significant concerns; and report nationally to Parliament.

44. Those requirements do not prevent local flexibility. They do not prescribe one engagement model or one provider of engagement work. They set the statutory floor below which no replacement patient voice system should fall. The Nuffield Trust suggests that, if Clauses 64 and 65 are not removed, one alternative would be to strengthen Schedule 10 so that ICBs must commission an independent body to obtain the views of service users or potential users (Nuffield Trust, 2026).

Conclusion

45. National Voices asks the Committee to remove Clause 64 and Clause 65, and the associated Schedules 9 and 10, so that Healthwatch England and Local Healthwatch organisations are retained.

46. If Parliament chooses to abolish Healthwatch England and Local Healthwatch, it should not leave the replacement model to guidance, future policy decisions or internal departmental design. National Voices supports Amendments 1-11 in the appendix to this submission because they place three sets of safeguards on the face of the Bill: national infrastructure through Amendments 1 and 2; local duties through Amendments 3, 5, 6, 8, 9 and 11; and equity duties through Amendments 4, 7 and 10.

47. The Bill as written abolishes statutory patient voice infrastructure, but does not yet place an equivalent statutory chain of listening, reporting, response, escalation and accountability in its place.

48. Parliament should not remove Healthwatch. If it does, the Bill should preserve, in statute, the functions that make patient, carer and service-user voice useful: independence where possible, transparency, reach into under-heard communities, cross-system sight, public reporting, and action on what people say.

References

Care Quality Commission (2026) Health Bill: written evidence submitted by Care Quality Commission to Public Bill Committee for the Health Bill.

Crisis, Groundswell, Homeless Link, Pathway and St Mungo's (2026) Health Bill Public Bill Committee evidence submission: improving health inequalities by giving a voice to underserved communities.

Department of Health and Social Care (2026) Health Bill: patient safety measures - impact assessments.

Healthwatch England (2026) Health Bill: supplementary evidence for the Public Bill Committee.

Morris, L., Wellings, D., Purbrick-Thompson, K. and Tiratelli, L. (2026) The future of patient voice: learning from the Healthwatch model. The King's Fund.

National Voices (2026) Health Bill: Second Reading Briefing - Protecting Patient Voice in the NHS and Social Care.

Nuffield Trust (2026) Written evidence submitted by the Nuffield Trust to the Bill Committee.

Picker (2026) NHS Modernisation Bill (Health Bill): Patient voice briefing.

Public Bill Committee (2026) Health Bill: First Sitting, Tuesday 16 June 2026 (Morning).

The Health Foundation (2026) Health Bill, Committee Stage: written evidence.

Appendix 1: Proposed amendments

Amendment 1: patient experience function

After Clause 65, insert—

"National patient experience and feedback function

(1) The Secretary of State must secure arrangements for the exercise of a national patient experience and feedback function in relation to health services and social care services in England.

(2) The national patient experience and feedback function is to—

(a) gather, analyse and publish evidence about the experiences of patients, carers and service users of health services and social care services;

(b) identify and report on recurring concerns arising from those experiences;

(c) identify and report on inequalities in access, experience and outcomes;

(d) identify and report on the extent to which the views obtained reflect the diversity of the population served, including groups whose views have not been adequately captured;

(e) make recommendations for improvement to the Secretary of State, integrated care boards, local authorities, the Care Quality Commission and such other bodies as the Secretary of State considers appropriate;

(f) provide a route for concerns arising from local patient, carer and service user voice arrangements to be escalated to national bodies.

(3) Arrangements under subsection (1) must secure—

(a) accessible routes for patients, carers, service users and the public to share views and concerns;

(b) specific arrangements to obtain and consider the views of people and communities who experience health inequalities, social exclusion, multiple disadvantage or other barriers to engagement and participation;

(c) arrangements for working with voluntary, community and social enterprise organisations;

(d) arrangements enabling findings, reports and recommendations to be published without prior approval by any body to which they relate;

(e) arrangements for recommendations made under subsection (2)(e) to receive a published response from the body to which the recommendation is made.

(4) The Secretary of State must lay before Parliament, at least once in each financial year, a report setting out—

(a) the principal findings of the national patient experience and feedback function;

(b) recurring concerns identified under subsection (2)(b);

(c) inequalities identified under subsection (2)(c);

(d) groups whose views have not been adequately captured;

(e) recommendations made under subsection (2)(e);

(f) responses received and action taken in response to those recommendations;

(g) cases where no response, or no sufficient response, has been received;

(h) an assessment of the impact of action taken in response to recommendations made in previous financial years."

Member's explanatory statement

This new clause would require the Secretary of State to secure a national function for gathering, publishing and escalating patient, carer and service-user experience evidence, and would require bodies receiving recommendations to publish a response.

Amendment 2: Patient Experience Director

After Clause 65, insert—

"National Patient Experience Director

(1) The Secretary of State must ensure an individual is in place as National Patient Experience Director in relation to health services and social care services in England.

(2) The functions of the Director are to—

(a) gather, analyse and publish evidence about the experiences of patients, carers and service users of health services and social care services;

(b) identify and report on themes, trends and learning arising from complaints and concerns, including action taken in response;

(c) identify and report on themes, trends and learning arising from patient, carer and service-user feedback;

(d) identify and report on inequalities in access, experience and outcomes, including inequalities experienced by people and communities facing social exclusion or multiple disadvantage;

(e) identify and report on the extent to which the views obtained reflect the diversity of the population served, including groups whose views have not been adequately captured;

(f) review the effectiveness of arrangements made by integrated care boards and local authorities for obtaining, considering and acting upon the views of patients, carers, service users and the public, including people and communities who experience health inequalities, social exclusion or multiple disadvantage;

(g) advise the Secretary of State, integrated care boards, local authorities and the Care Quality Commission on the use of patient, carer and service-user experience evidence in oversight and improvement;

(h) make recommendations to the Secretary of State, integrated care boards, local authorities, the Care Quality Commission and such other bodies as the Director considers appropriate.

(3) The Director must appoint an advisory group to provide the Director with advice and assistance relating to the discharge of the Director's functions.

(4) The advisory group must include persons who, taken together, represent a broad range of interests relevant to the Director's functions, including—

(a) patients and service users;

(b) carers;

(c) voluntary, community and social enterprise organisations;

(d) persons with experience of health inequalities, social exclusion or multiple disadvantage.

(5) The Director may publish findings, recommendations and advice in connection with the exercise of functions under this section, including in reports other than the annual report prepared under subsection (6).

(6) As soon as practicable after the end of each financial year, the Director must prepare an annual report on—

(a) the way in which the Director's functions have been discharged; and

(b) what the Director has found in the course of exercising those functions during the year.

(7) The Director must—

(a) lay the report before Parliament; and

(b) publish the report.

(8) The report must, in particular, include—

(a) the principal issues raised by patients, carers and service users;

(b) inequalities identified in access, experience and outcomes;

(c) groups whose views have not been adequately captured;

(d) recommendations made by the Director;

(e) responses received and action taken in response to those recommendations;

(f) cases where no response, or no sufficient response, has been received;

(g) an assessment of the impact of action taken in response to recommendations made in previous financial years."

Member's explanatory statement

This new clause would require the Secretary of State to appoint a National Patient Experience Director with functions relating to patient, carer and service-user experience evidence, complaints learning, engagement practice, inequalities and improvement. It would require the Director to appoint an advisory group and to lay and publish an annual report.

Amendment 3: local voice duty (ICBs)

Schedule 10, page 126, line 30, leave out "such arrangements as it considers appropriate to obtain" and insert—

> "effective, accessible and proportionate arrangements for obtaining, analysing, publishing and responding to"

Member's explanatory statement

This amendment would require integrated care boards to make effective, accessible and proportionate arrangements to obtain, analyse, publish and respond to the views of users or potential users of services.

Amendment 4: under-served people and communities (ICBs)

Schedule 10, page 127, line 4, at end insert—

> "[3] (a) In making arrangements under subsection (2), an integrated care board must take reasonable steps to obtain the views of people and communities who are likely to experience health inequalities, including people who experience barriers arising from disability, deprivation, social exclusion, language, digital exclusion or discrimination.
>
> (b) Where people and communities under subsection (3a) are unlikely or unable to engage directly, the integrated care board must secure appropriate arrangements, including through voluntary, community and social enterprise organisations with relevant expertise or trusted relationships, to facilitate their participation."

Member's explanatory statement

This amendment would require integrated care boards to take reasonable steps to obtain the views of people and communities likely to experience health inequalities, including those facing barriers to engagement, and to make appropriate arrangements to support participation where standard engagement routes are unlikely to reach them.

Amendment 5: "you said, we did" (ICBs)

Schedule 10, page 127, line 12, at end insert—

"(6) An integrated care board must publish, at least once in each financial year—

(a) a summary of views obtained under subsection (2);

(b) information about the people and communities from whom views were obtained and, so far as reasonably practicable, those from whom views were not obtained;

(c) an explanation of how those views have been considered;

(d) a statement of action taken or proposed in response to matters arising from those views, or reasons for taking no action;

(e) an assessment of the impact of action taken in response to matters arising from those views;

(f) a statement of concerns escalated to the Secretary of State, the Care Quality Commission or other relevant bodies.

(7) An integrated care board must maintain arrangements for sharing significant patient, carer and service-user concerns with relevant oversight bodies in a timely manner."

Member's explanatory statement

This amendment would require integrated care boards to publish an annual account of the views they have obtained, who they have and have not heard from, how those views have been considered, what action has been taken or proposed in response, and what significant concerns have been escalated.

Amendment 6: local voice duty (public health services)

Schedule 10, page 127, line 28, leave out "such arrangements as it considers appropriate to obtain" and insert—

"effective, accessible and proportionate arrangements for obtaining, analysing, publishing and responding to"

Member's explanatory statement

This amendment would require local authorities to make effective, accessible and proportionate arrangements to obtain, analyse, publish and respond to the views of users or potential users of public health services.

Amendment 7: under-served people and communities (public health)

Schedule 10, page 127, line 37, at end insert—

"[3] (a) In making arrangements under subsection (2), a local authority must take reasonable steps to obtain the views of people and communities who are likely to experience health inequalities, including people who experience barriers arising from disability, deprivation, social exclusion, language, digital exclusion or discrimination.

(b) Where people and communities under subsection (3a) are unlikely or unable to engage directly, the local authority must secure appropriate arrangements, including through voluntary, community and social enterprise organisations with relevant expertise or trusted relationships, to facilitate their participation."

Member's explanatory statement

This amendment would require local authorities to take reasonable steps to obtain the views of people and communities likely to experience health inequalities, including those facing barriers to engagement, and to make appropriate arrangements to support participation where standard engagement routes are unlikely to reach them.

Amendment 8: "you said, we did" (public health)

Schedule 10, page 128, line 5, at end insert—

"(6) A local authority must publish, at least once in each financial year—

(a) a summary of views obtained under subsection (2);

(b) information about the people and communities from whom views were obtained and, so far as reasonably practicable, those from whom views were not obtained;

(c) an explanation of how those views have been considered;

(d) a statement of action taken or proposed in response to matters arising from those views, or reasons for taking no action;

(e) an assessment of the impact of action taken in response to matters arising from those views;

(f) a statement of concerns escalated to the Secretary of State, the Care Quality Commission or other relevant bodies.

(7) A local authority must maintain arrangements for sharing significant patient, carer and service-user concerns with relevant oversight bodies in a timely manner."

Member's explanatory statement

This amendment would require local authorities to publish an annual account of the views they have obtained, who they have and have not heard from, how those views have been considered, what action has been taken or proposed in response, and what significant concerns have been escalated.

Amendment 9: local voice duty (social care)

Schedule 10, page 129, line 14, leave out "such arrangements as it considers appropriate to obtain" and insert—

"effective, accessible and proportionate arrangements for obtaining, analysing, publishing and responding to"

Member's explanatory statement

This amendment would require local authorities to make effective, accessible and proportionate arrangements to obtain, analyse, publish and respond to the views of users or potential users of social care services.

Amendment 10: under-served people and communities (social care)

Schedule 10, page 129, line 23, at end insert—

"(3a) In making arrangements under subsection (2), a local authority must take reasonable steps to obtain the views of people and communities who are likely to experience health inequalities, including people who experience barriers arising from disability, deprivation, social exclusion, language, digital exclusion or discrimination.

(3b) Where people and communities under subsection (3a) are unlikely or unable to engage directly, the local authority must secure appropriate arrangements, including through voluntary, community and social enterprise

organisations with relevant expertise or trusted relationships, to facilitate their participation."

Member's explanatory statement

This amendment would require local authorities to take reasonable steps to obtain the views of people and communities likely to experience health inequalities, including those facing barriers to engagement, and to make appropriate arrangements to support participation where standard engagement routes are unlikely to reach them.

Amendment 11: "you said, we did" (social care)

Schedule 10, page 129, line 31, at end insert—

"(7) A local authority must publish, at least once in each financial year—

(a) a summary of views obtained under subsection (2);

(b) information about the people and communities from whom views were obtained and, so far as reasonably practicable, those from whom views were not obtained;

(c) an explanation of how those views have been considered;

(d) a statement of action taken or proposed in response to matters arising from those views, or reasons for taking no action;

(e) an assessment of the impact of action taken in response to matters arising from those views;

(f) a statement of concerns escalated to the Secretary of State, the Care Quality Commission or other relevant bodies.

(8) A local authority must maintain arrangements for sharing significant user, potential user, carer and representative concerns with relevant oversight bodies in a timely manner."

Member's explanatory statement

This amendment would require local authorities to publish an annual account of the views they have obtained, who they have and have not heard from, how those views have been considered, what action has been taken or proposed in response, and what significant concerns have been escalated.