

PUBLIC BILL COMMITTEE: HEALTH BILL

Written evidence from the County Councils Network (CCN)

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The draft Health Bill provides for a number of changes of relevance and concern to CCN members, including the abolition of Healthwatch and transferring of local Healthwatch functions to ICBs and local authorities, and the extension of a single patient record to include adult social care data. We support the Local Government Association and ADASS (Association of Directors of Adult Social Services) in their representations on these issues.

Our evidence submission is focused on the proposal to change who is represented on ICBs.

1. ***A mandated seat for local authority representation is necessary to ensure the success of ICBs' strategic commissioning function, the ability of local authorities to discharge their own duties, and to the success of the neighbourhood health agenda.***
- 1.1 **Local authorities are the largest commissioners of adult social care and support in the country.** The CCN recognises the government's commitment to reinvigorate the strategic commissioner function of ICBs. We recognise the diversity of local relationships, structures and approaches to partnership working. We understand – though make no comment on – the move to reduce the provider-heavy composition of ICBs. However, while LAs do directly provide some care and support services, they are also the largest commissioners of adult social care and support in the country. They are local leaders in strategic commissioning, with insight, expertise and experience that should be utilised within ICBs.
- 1.2 **ICB commissioning decisions directly impact local care markets and LAs have duties under the Care Act 2014 to shape and stabilise local care markets.** It is essential that local authorities are directly represented on ICBs. The Statutory Officer role of Director of Adult Social Services (DASS) holds an associated individual duty. Statutory Officers hold personal liabilities that are not replicated – and we are concerned may sometimes be misunderstood – at a national level. We do not consider an ICB member “nominated by the mayor of each mayoral strategic authority” to be a sufficient representative of these organisational and individual duties.
- 1.3 **County and rural areas face different realities to metropolitan areas, with unique populations, geographies, workforces and care markets.** CCN member authorities have populations with a higher average age than urban areas, and our older populations are growing in size. Care provision is framed by rurality and sparsity, including longer distances between people drawing on care. Smaller providers are essential, as larger providers tend to avoid the complexity of delivering across these geographies. Third sector infrastructure is often driven by geographic diversity. The national workforce challenges are compounded in county areas.

Lower population densities mean fewer job seekers, and people do not necessarily want to work over long distances and disparate geographies. County areas have diverse and fragmented care markets. Local authority market shaping is essential.

1.4 NHS challenges of rurality and sparsity impact local authority planning, commissioning and delivery, particularly in adult social care. For example, the location of teaching hospitals, the higher education pipeline and the reach of professional networks all impact the availability of allied health professionals, specialists, and so on. Full collaboration is essential.

1.5 History shows that efforts to progress preventative and neighbourhood health approaches are improved when local authorities are structurally embedded through the full planning, commissioning and delivery cycle. This was well-evidenced through the World Class Commissioning work of the mid-2000s and is closely linked to the attainment of outcomes (people, systems and economic) being dependent on social care, housing, public health, communities, universal services, and the broader place-shaping work of councils.

1.6 Local authorities hold specialist knowledge and are the convenors of functions and services that are essential to the success of neighbourhood health. These include (but are not limited to) public health, housing, education, VCSE infrastructure and engagement, community development and co-design of services. It is particularly vital that ICBs retain a named SEND lead. Government's reforms are essential and inevitable, but they need health to play its full role in conjunction with schools, local authorities and families to succeed. We will lose essential local knowledge and experience if we remove local authorities from ICBs – we do not believe it can be adequately replicated through mayoral strategic authorities.

- Various research studies have interrogated these issues, for example:

Alderwick, H., Hutchings, A. & Mays, N. Cross-sector collaboration to reduce health inequalities: a qualitative study of local collaboration between health care, social services, and other sectors under health system reforms in England. *BMC Public Health* 24, 2613 (2024). <https://doi.org/10.1186/s12889-024-20089-5>

This research from the Department of Health Services Research and Policy, London School of Hygiene & Tropical Medicine found ICS staff repeatedly highlighted that local authorities had been working on health inequalities long before the creation of ICSs. They recognised that expertise on the wider determinants of health, public health, community engagement and place-based working often sat within local government rather than the NHS.

1.7 The government's own guidance, published only six months ago, explicitly states that specialist public health advice should be embedded within ICB commissioning processes. ICBs are responsible for improving population health and reducing health inequalities – both of which depend heavily on knowledge and expertise that sit largely within local authority public health teams. Local authorities have a legal role in providing this advice to support strategic commissioning, health improvement, and reduction of inequalities. Removing the mandated seat for local authority representation on ICBs will undermine this work and the government's own efforts to assure them.

- More information: DHSC (2026). [Guidance: Providing healthcare public health advice to integrated care boards.](#)

1.8 Local Government Reorganisation will have significant impacts on strategic commissioning that must be understood and accounted for by ICBs. This could include shifts to short-term commissioning cycles and contract awards as local authorities work toward their dissolution. Shadow authorities will also need a route into ICBs to ensure priorities, commitments and commissioning are aligned.

1.9 A duty to cooperate is insufficient to ensure equal and active partnership between health bodies and local authorities. While we recognise statutory design also has its limits, decades of institutional knowledge – gained through work to support Primary Care Trusts, Clinical Commissioning Groups, World Class Commissioning, Integrated Care Systems, Boards and Partnerships, Sustainability and Transformation Plans, and so on – shows us a mandated seat on ICBs for local authority representation is nonetheless a necessary foundation for partnership.

2. Replacing local authority representation on ICBs with a member nominated by the mayor of each mayoral strategic authority is not equivalent. This work is not the job of mayors.

2.1 Mayoral strategic authorities do not run statutory adult social care, children’s services, safeguarding, or most public health delivery – councils do. Even Greater Manchester Combined Authority does not hold the legal duties for statutory services. We cannot understand the logic of this proposed shift from direct local authority representation to representation from organisations that control *fewer* aspects of the determinants of health and hold none of the associated legal duties.

2.2 Replacing local authority representation on ICBs with an idea of representation through mayoral strategic authorities risks recreating the two-tier local government that the Local Government Reorganisation (LGR) programme is seeking to eliminate. It introduces a new layered governance model in health and care that will result in fewer councils but more tiers of governance. The UK Government argues through its LGR programme that too many overlapping functions weaken accountability, yet the draft Health Bill’s proposed reconstitution of ICBs removes the line of accountability between strategic commissioning and the delivery of statutory services. Strategic authorities are intended to be regional convenors and leaders of economic growth. We strongly believe they should be enabled to do justice to these functions rather than have new functions assigned to them that they do not hold the legal duties to deliver. We reiterate here that Statutory Officers hold personal liabilities that are not replicated at national or *regional* level.

2.3 A further layering of governance and accountability is created by providing for local authority representation on ICBs within mayoral strategic authority areas through primary legislation, while providing for representation within areas without mayoral strategic authorities through guidance. The DHSC policy paper ‘[Health Bill: ICBs as strategic commissioners – fact sheet](#)’ notes: ‘For areas which currently do not have strategic authorities, membership arrangements will be clarified in guidance’. One stated intention of LGR is to streamline accountability to aid democratic literacy. We do not believe a mixed legislative approach to local authority representation on ICBs aligns with this intention.

3. ***We do not believe it is possible to mitigate the negative impacts of replacing local authority representation on ICBs with a member nominated by the mayor of the mayoral strategic authority.***
 4. ***However, we do believe there may be alternative models of mandated local authority representation on ICBs and would welcome an opportunity to explore these with the Committee.***
 - 4.1 **We recognise the challenge of achieving adequate representation of multiple local authorities on one ICB.** We reject the proposed model and do not consider it to be a better alternative to the mandated local authority seat.
 - 4.2 **There are opportunities to learn from approaches taken in other programmes of work, including policing reforms.** CCN would welcome an opportunity to share our learning and expertise.
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The County Councils Network (CCN) is the voice of England's counties. Representing the local authorities in county areas, the network is a cross-party organisation which develops policy, commissions research, and presents evidence-based solutions to issues on behalf of the largest grouping of councils in England.

In total, the 21 county councils and 18 unitary councils that make up the CCN represent 27 million residents, account for 39% of England's GVA, and deliver high-quality services that matter the most to local communities. The majority of our members are impacted by the UK Government's Local Government Reorganisation (LGR) programme.