House of Commons

Health Committee

Work of the Committee 2005–06

Second Report of Session 2006–07

Report, together with formal minutes

Ordered by The House of Commons
to be printed 1 February 2007

HC 297
Published on 9 March 2007
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Kevin Barron MP (*Labour, Rother Valley*) (Chairman)
Mr David Amess MP (*Conservative, Southend West*)
Charlotte Atkins MP (*Labour, Staffordshire Moorlands*)
Mr Ronnie Campbell MP (*Labour, Blyth Valley*)
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Mike Penning MP (*Conservative, Hemel Hempstead*)
Dr Howard Stoate MP (*Labour, Dartford*)
Dr Richard Taylor MP (*Independent, Wyre Forest*)

Mr Paul Burstow MP (*Liberal Democrat, Sutton & Cheam*) and Anne Milton MP (*Conservative, Guildford*) were Members of the Committee during this period

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Emma Graham (Second Clerk), Christine Kirkpatrick (Committee Specialist), Ralph Coulbeck (Committee Specialist), Duma Langton (Committee Assistant), Julie Storey (Secretary), Jim Hudson (Senior Office Clerk) and Luke Robinson (Media Adviser).

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1 Introduction

1. The new Committee set up after the General Election in 2005 has continued the practice of its predecessor committees in examining a wide range of matters. In the past session this has included public health, NHS finance, the administration of the NHS, workforce planning and the increased involvement of private healthcare providers in the health service.

2. The highlight of the period covered in this report from July 2005 to December 2006 was the Committee's Report on *Smoking in Public Places* which was instrumental in persuading the House to amend the Health Bill and include a more comprehensive ban (see paras 14-18). A major theme has been the financial situation in the National Health Service. The Committee carried out an important inquiry into *NHS Deficits*[1] and continued its annual *Public Expenditure Questionnaire* [*PEQ*] exercise (see paras 24-27). One of the causes of the NHS's deficits has been the failure to co-ordinate financial and workforce planning: the Committee started a major inquiry into *Workforce Planning* which should be published in the first half of 2007. We published the following Reports:

First Report (Session 2005-06)	*Smoking in Public Places* (HC 485–I)
Second Report	*Changes to Primary Care Trusts* (HC 646)
Third Report	*NHS Charges* (HC 815–I)
Fourth Report	*Independent Sector Treatment Centres* (HC 934–I)
First Report (Session 2006-07)	*NHS Deficits* (HC 73-I)

3. The Committee has taken evidence from Ministers on several occasions. The Committee questioned the Secretary of State as part of the *PEQ*, *Independent Sector Treatment Centres* (*ISTCs*) and *NHS Deficits* inquiries. We also held an evidence session with her on her full portfolio of responsibilities soon after we were set up. We have held similar sessions with Rosie Winterton MP, the Minister of State for Health Services, and Andy Burnham MP, the Minister of State for Delivery and Quality and intend to call other Ministers in the Department to answer on their responsibilities. We have also taken evidence from senior civil servants including the Permanent Secretary of the Department, the Chief Executive of the NHS and the Department of Health's Finance Director.

4. We undertook a number of visits in connection with our inquiries. In the course of our inquiry into *ISTCs* we went to three treatment centres in the south of England, including a privately managed Treatment Centre at Gillingham, an NHS Treatment Centre at Dartford and the Redwood Treatment Centre which is a partnership [outside the ISTC programme] between BUPA and the NHS.

5. Since prescription charges are to be abolished in Wales, we visited Cardiff as part of the *NHS Charges* Inquiry, meeting the Minister for Health and Social Services, Assembly Members, including past and present Committee chairmen and senior civil servants in the

1 The *NHS Deficits* inquiry concluded just after prorogation and the Report was published on 13 December 2006

Department of Health and Social Care. We were able to discuss the arguments for abolition, in particular the difficulty in reforming the system of exemptions.

6. In 2005 as part of the inquiry into *Smoking in Public Places* the Committee visited Dublin where a comprehensive ban is already in force. The possible consequences of a smoking ban in England have been much debated; we were able to find out what the actual consequences had been in Ireland. We also met those who worked in the industries affected and those responsible for the implementation and enforcement of the legislation.

7. We visited Sweden in relation to our inquiries into *NHS Charges* and *ISTCs*. In Stockholm we met the Parliamentary Committee on Health and Welfare and the state-owned pharmacy Apoteket. We also met officials from local, regional and municipal government who provide healthcare in Sweden, and the Ministry of Health and Social Affairs who frame and monitor health policy. In addition, members of the Committee were shown round a privately run hospital, managed by Capio, a Swedish company that is now operating in England. The visit gave the Committee the opportunity to study how a system of patient charges quite different from those used in England work within a widely admired healthcare system.

8. The Committee went to San Francisco as part of the inquiry into *Workforce Planning*. We met academic experts, policy makers and health service providers with workforce expertise to discuss how planning is done in a free market system and the likely shape of the future workforce. Representatives of Kaiser Permanente explained how the workforce is planned and managed in the largest healthcare provider in the US. Experts from the Center for California Health Workforce Studies provided an insight into workforce planning across the US and some interesting contrasts between the UK and the US workforces. Senators at the State Legislature gave the Committee an insight into the limited role of the state in workforce planning and the willingness to rely on overseas clinicians to make up any shortages. A highlight of the trip was a stimulating discussion with Bob Brook, Director of RAND Health, who challenged many of the Committee's perceptions and shared some innovative ideas about the future of the healthcare workforce in the UK and beyond. The Committee also found time to visit US hospital facilities in San Francisco. We are very grateful to all those who put so much work into briefing the Committee during our visits and to the FCO officials who organised them.

9. The Committee also received visitors from overseas Parliaments, including a delegation of Czech Parliamentarians who wanted to discuss the role of the private sector in healthcare in England, and Irish Parliamentarians who wanted to discuss developments following our Report on the *Influence of the Pharmaceutical Industry*.

10. Our relations with the Department of Health have in general been good. Ministers and officials have been helpful and have readily attended evidence sessions when requested. However, some aspects of the relationship have been unsatisfactory. As part of the *ISTC* inquiry we asked the Department for information about value for money, including a study the Department had commissioned of the ISTC programme and its effect on the NHS. Although other Committees have been shown similar evaluations of schemes, our request was refused on grounds of commercial confidentiality which made it difficult for us to draw conclusions about the programme. In the same inquiry the Secretary of State gave evidence to us about the ISTC programme which failed adequately to describe what was

happening in respect of Phase 2 of the programme.[2] We were also disappointed that none of the Government witnesses to the *Smoking in Public Places* inquiry chose to inform the Committee that the legislation would not extend to Crown Property.

11. While there have been a few problems, for the most part we have found the Department helpful. We would like to thank those in the Parliamentary section, who have efficiently and courteously transmitted our requests for information to relevant sections of the Department. In addition, we would like to thank all those involved in preparing the answers to the *PEQ*. We do appreciate the amount of work that goes into producing the document. We must also thank Adam Mellows Facer from the House of Commons Library for his assistance in revising the *PEQ*.

2 In our Report on *Independent Sector Treatment Centres*, we noted, "There has been confusion about the scale and nature of Phase 2. When the Secretary of Stae gave oral evidence on 26 April 2006, she told us that ITNs had been issued for 12 elective schemes, in two tranches, and that responses had been received for five of those bids. However, the Health Service Journal reported the next day that Phase 2 had originally comprised 24 schemes, of which seven had subsequently been scrapped, with only 17 proceeding (perhaps with some delay).The Secretary of State conceded in a letter to the Committee that Phase 2 would indeed probably consist of 17 schemes." HC (2005-06) 934-I, para 23

Core Tasks

12. Select Committees have been asked by the Liaison Committee to perform certain core tasks[3] which are designed to provide a framework to encourage 'a more methodical and less ad-hoc approach to the business of scrutiny'.[4]

13. They are grouped under four separate objectives:

Objective A: To examine and comment on the policy of the Department

Objective B: To examine the expenditure of the Department

Objective C: To examine the administration of the Department

Objective D: To assist the House in debate and decision.

Objective A: To examine and comment on the policy of the Department

Task 1: To examine policy proposals from the UK Government and the European Commission in Green Papers, White Papers, Draft Guidance etc, and to inquire further where the Committee considers it appropriate

Task 4: To examine specific output from the Department expressed in documents or other decisions

14. Our inquiry into *Smoking in Public Places* provides an excellent example of a Select Committee commenting on policy proposals. The inquiry was prompted by the Government's stated intention, initially in the White Paper *Choosing Health*,[5] to bring forward legislation to reduce smoking. The Government carried out a consultation in the summer of 2005 and, on that basis, published the Health Bill in October 2005.

15. The Bill contained proposals to ban smoking in public places and workplaces, but with certain exemptions, in particular for private members' clubs and bars which do not serve food. During the oral evidence sessions we were able to investigate the rationale for the partial ban. The evidence we received indicated that ventilation would not be a cost-effective option. We also found that many in the entertainment industry, who were portrayed as being against the ban, actually preferred a full ban because they wanted fair competition. The core of the argument revolved around workers in 'smoking bars', who are most at risk from second-hand smoke. The Committee considered the issue as a matter of health and safety and concluded that workers should not have to work in a smoky bar just as they should not be exposed to asbestos in the workplace.

3 *Votes and Proceedings*, 14 May 2002, p 864–5

4 Liaison Committee, Second Report of Session 2001–02, *Select Committees: Modernisation Proposals*, HC 692, para 16

5 Cm 6374

16. We also found that a comprehensive ban was likely to be easier to enforce than a partial ban. The Government's proposals were based on the premise that the public would only accept a partial ban and therefore compliance with a full ban would be problematic. The Committee received evidence that public support for a total ban was much higher than the Government claimed. We found statements in the Government's White Paper *Choosing Health* on this issue misleading.

17. The key moment in the inquiry was the evidence session with the Chief Medical Officer, Sir Liam Donaldson, who told us that he had advised the Government to institute a full ban. In his Annual Report for 2005 he referred to 'the scourge of tobacco-related illness and death, which remains the most significant public health problem in our country.'[6] In oral evidence to the Committee Sir Liam admitted it was the first time in seven years that his advice had been ignored and as a result he admitted to having considered resigning.[7]

18. The Committee's Report contributed substantially to demands for a complete ban, and culminated with the Government introducing a new clause removing the exemptions at Report stage and agreeing to allow a free vote on the matter.[8] The Committee's Report was referred to throughout the debate and the Bill was amended. In its response to the Committee the Government said,

> The Government agrees with the Health Select Committee that the only genuine solution to the problem of second-hand smoke exposure is to ensure that enclosed and substantially enclosed public places and workplaces become smoke-free. This solution is also the one clearly favoured by the House of Commons, given the amendments made to the Health Bill during Report Stage.[9]

19. The Government published *Commissioning a Patient Led NHS* on 28 July 2005, the House of Commons having risen for the summer recess on Thursday 21 July. It contained proposals to reduce the number of Primary Care Trusts and Strategic Health Authorities, change commissioning and provider responsibilities and contract out community health services to non NHS providers. Our *Changes to Primary Care Trusts* inquiry was an examination of these proposals and the potential implications. We found widespread disaffection with the constant organisational change. The situation was exacerbated in this case because the PCTs which were to be merged had been established just three years previously and had not had time to establish themselves. There was also intense dissatisfaction with the consultation process which was carried out over the summer holidays; witnesses described it as insufficient and flawed.

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6 The Department of Health, *The Chief Medical Officer on the state of public health*, Annual Report 2005

7 First Report of Session 2005–06, *Smoking in Public Places*, HC 485–III, Qq 446–456

8 The Committee took evidence from the Chief Minister Officer and from the Minister on 24 November 2005. The Committee's Report was published Monday 19 December 2005. The Chairman proposed an amendment to the Bill on 10 January 2006, which was withdrawn when the Government agreed to table their own new clause for the Report stage on 14 February 2006.

9 Department of Health, Government Response to the House of Commons Health Committee's First Report of Session 2005–06, *Smoking in Public Places*, March 2006, Cm 6769

Task 2: To identify and examine areas of emerging policy, or where existing policy is deficient, and make proposals

20. The Committee has a long tradition of examining areas where policy is deficient. We have undertaken a number of inquiries since the 2005 General Election which fall into this category. The *NHS Charges* inquiry aimed to uncover the rationale behind the range of payments that patients are asked to contribute towards the provision of care. The Committee found no apparent underlying principle and a substantial amount of historical baggage. The system is full of anomalies. In particular the Committee were unimpressed to find that the list of medical exemptions from prescription charges was compiled in 1968 and had not changed since. In its response the Government agreed to a review of the exemption list. It also agreed to improve the guidance to Trusts on hospital car parking, continue to review the costs to users of bedside television and telephone systems and consult on how to improve the Hospital Travel Costs Scheme.

21. Our major inquiry has been into *Workforce Planning*. The longer the inquiry has continued the more relevant and important it has seemed as the years of rapid expansion have given way to reductions in posts and great difficulties for newly qualified staff in finding jobs. We have been looking at why workforce planning structures failed to prevent the boom-bust cycle and how to make changes to stop the mistakes being repeated. Oral evidence sessions conclude in January 2007. The Committee hopes to publish this major report before Easter 2007.

22. We also examined the Government's increasing use of the private sector to provide health care in our inquiry into *Independent Sector Treatment Centres*. We looked at whether the first wave of ISTCs had provided value for money and what changes should be made in the second wave which was announced in March 2005. The Government claimed a number of benefits for the scheme, in particular that competition would provide a spur to the NHS to improve. We found it impossible to establish whether this was the case or whether ISTCs had provided value for money because the Government either had not collected the relevant data or would not provide us with the data it had. Lack of data also meant that we were unable to establish the quality of care provided by the ISTCs. For the same reasons we concluded that alarmist statements about the care provided by these centres could not be justified. In addition we were concerned that ISTCs had so far failed to provide training and were poorly integrated into the NHS. We concluded that separating elective care from emergency care in treatment centres was a good idea, but we were not persuaded that private sector treatment centres offered better value for money than NHS treatment centres or centres which are based on a partnership between the NHS and the private sector such as at Redwood in Surrey.

23. The one-off oral evidence sessions which we hold to examine the responsibilities of Ministers in the Department of Health also enables us to consider deficiencies in Government policy.[10] For example, we took evidence from Andy Burnham, Minister for Delivery and Quality on hospital acquired infections, waiting time targets, NICE, the

10 Oral evidence taken before the Health Committee on 26 January 2006, *Responsibilities of the Minister of State for Health Services*, HC 866; and Oral evidence taken before the Committee on 26 October 2006, *Responsibilities of the Minister of State for Delivery and Quality*, HC 1691

MHRA, the home oxygen service and the new community pharmacy contract.[11] In some cases the Committee has decided to carry out a full inquiry into the subjects covered, for example, we will be looking in more detail at NICE later in 2007.

Task 3: To conduct scrutiny of any published draft bill within the Committee's responsibilities

24. The Department of Health did not publish any draft Bills in this session. However, the Committee has examined aspects of bills after second reading. As described above, we looked at the provisions relating to smoking in the Health Bill and reported in time to influence the debate at report stage, We intend to undertake a similar exercise in respect of the patient and public involvement of health aspects of the Local Government and Public Involvement in Health Bill. Evidence sessions will begin in February and we intend to report before Easter.

11 Oral evidence taken before the Committee on 26 October 2006, *Responsibilities of the Minister of State for Delivery and Quality*, HC 1691

Objective B: To examine the expenditure of the Department

Task 5: To examine the expenditure plans and outturn of the Department, its agencies and principal BDBPs

25. The Committee takes very seriously its responsibilities to examine the expenditure of the Department and NHS. For many years the Committee has undertaken an annual inquiry into the subject. Each year the Committee sends a questionnaire to the Department asking for answers to a range of questions under headings such as expenditure, investment, reform and forward planning, spending programmes, activity & efficiency and includes information relating to the Department's Arm's Length Bodies. This year with the assistance from the House of Commons Library we undertook a major revision of the questionnaire to improve the type and layout of the information gathered and make it more accessible to readers. Nevertheless, many of the questions in the *PEQ* remain the same, seeking updated figures. They provide an important data series.

26. The Department's response to the questionnaire provides a vast amount of detail on the financial situation of the NHS and the Department. After receipt of the *PEQ* the Committee holds two evidence sessions. The first was with senior officials from the Department, which this year included the Permanent Secretary and the Chief Executive of the NHS, the second with the Secretary of State.

27. The *PEQ* sessions allow the Committee to explore a range of financial issues not covered in other inquiries; this year they included Private Finance Initiative projects and the National Programme for IT. The Committee's questions revealed details about management consultant spending which were not previously publicly available and which were subsequently widely reported in the media. The sessions also allowed the Committee to question the Permanent Secretary about the running of the Department of Health following the recent reduction in staff posts.

28. We also carried out two inquiries which were directly related to expenditure and NHS finances. In our inquiry into *NHS Deficits* we examined the reasons for the deficits which have been revealed over the last two years. We found that, although deficits had grown, the underlying deficits were often of long-standing. They have been revealed by increasing transparency, in particular the introduction of the RAB accountancy regime. We found the deficits had several causes. Some large deficits were caused by historic difficulties. Other causes were the funding formula and poor financial management both by the Department of Health and by NHS trusts. We were concerned by the consequences of the steps taken to reduce the deficits, in particular the cuts in training budgets. The Secretary of State told us in evidence that she would take personal responsibility for ensuring the NHS is in balance by the end of March 2007.[12] We will pay close attention to the progress in this area. It is important that it is not achieved by a continuing neglect of training.

29. Our inquiry into *NHS Charges* looked at how patients contribute to the funding the health service and at the principles underlying patient contributions to the NHS. We could find no rationale as to what was and was not charged for. Charges have been introduced in

a piecemeal fashion and there has been no detailed analysis of the consequences of charges for people's health and of other ways of charging. We were surprised to find that the Government has not sought to collect the evidence. We recommended that the Government review present charges and collect evidence about their consequences, and it should also look at alternative charging systems.

30. Other inquiries have had an expenditure element. One of the reasons the Government gave for reorganising PCTs was that it would enable savings of up to £250 million to be made. The Committee doubted that the proposed savings would be made.

31. In the *ISTCs* inquiry we considered the increasing sums spent on private sector providers and whether they provided value for money. Various rationales have been put forward for the ISTCs. Under questioning the Department of Health admitted that the main benefits of the first wave of ISTCs were not, as is often claimed, additional capacity [which was relatively small] but the spur they gave to the NHS to improve. Given this we were surprised that the Department had made no attempt to measure this effect. Our work was frustrated by the Department's unwillingness to provide the Committee with its assessment of these consequences. As we noted above, we were also on grounds of commercial confidentiality denied financial data relating to the programme. This means that the Committee was unable to effectively scrutinise a £5 billion project. The Committee recommended that the NAO investigate the value for money aspect of the programme.

Objective C: To examine the administration of the Department

Task 6: To examine the Department's Public Service Agreements, the associated targets and the statistical measurements employed, and report if appropriate

32. We continued the practice of our predecessors in examining Public Service Agreements in our *Public Expenditure* Inquiry For example, we questioned the Permanent Secretary and Secretary of State on Target 10 from 2000 on Value for Money and Target 12 from 2002 on Improving Value for Money.

33. The performance targets which the Department has imposed on the NHS have inevitably been a feature of our work. We were alarmed by the failure to adequately cost and pilot these targets. In our inquiry into *NHS Deficits* witnesses stressed the cost of meeting the 4 hour Accident and Emergency (A and E) target, which we were told had made a significant contribution to the deficits. Too little thought had been given to cost/benefit ratio of marginal changes to the target, for example, of ensuring that 98% of patients had a maximum wait of 4 hours in A and E rather than 95%.

34. In our session with Andy Burnham, the Minister of State, we were able to ask more questions about the A and E target. We also questioned him about a number of other targets, including:

- Target 1 from 2002 [to reduce the maximum wait for an outpatient appointment to three months and the maximum wait for in-patient treatment to six months by end of 2005 with further progress… by 2008]
- Target 4 [to tackle health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people, reduce emergency bed days, and improve primary care and community settings for those with long-term conditions]
- Target 5 [to ensure by 2008 no one waits more than 18 weeks from GP referral to hospital treatment]

35. Many of our other inquiries involved the consideration of PSA targets. At the heart of our study of *Workforce Planning* is Objective VI: to manage the staff and resources of the Department so as to improve performance. The *Sexual Health* debate arising from our report in the last Parliament touched on Target 3: to tackle the underlying determinants of health and health inequalities by reducing the under 18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health.

36. Smoking is such an important determinant of health that our inquiry into the subject involved us in considering several targets, including the following Departmental PSA Targets 2004:

- Target 1 'improve the Health of the Population'—substantially reduce mortality rates by heart disease, stroke and related diseases by 40% in under 75s… and reduce inequalities gap from cancer by at least 20%

- Target 2 reduce health inequalities as measured by life expectancy at birth and infant mortality
- Target 3 tackle the underlying determinants of health and health inequalities by reducing smoking rates to 21% or less by 2010 and in certain groups to 26%.

Task 7: To monitor work of the Department's Executive Agencies, NDPBs, regulators and other associated bodies

37. The Committee has continued to monitor the work of the Department's Arms Length Bodies. In the course of the inquiry into *ISTCs* we took oral evidence from the Healthcare Commission on the quality of care provided by private sector providers. We also heard from Monitor during the Deficits inquiry. We also received written evidence from NICE on *Smoking*, CPPIH on *Changes to PCTs* and *NHS Deficits*, and from the Healthcare Commission on *ISTCs*, *Workforce Planning* and *NHS Deficits*.

38. In our evidence sessions with Ministers we have been able to address the work and effectiveness of these bodies. We questioned Andy Burnham about the National Institute for Health and Clinical Excellence, the National Patient Safety Agency and the Medical Healthcare Products Regulatory Agency. Rosie Winterton was questioned about the work of the Commission for Patient and Public Involvement in Health and the Healthcare Commission.

39. Since the new Committee was appointed in 2005 the Chairman has held regular informal meetings which other members of the Committee also attend; many of the meetings are with the Chairs or Chief Executives of the Department's Arm's Length Bodies and provide an excellent opportunity to discuss any mutual issues of concern. In these meetings we have met the Commission for Social Care Inspection, Healthcare Commission, Food Standards Agency, NHS Direct, Medicines and Healthcare Products Regulatory Agency, Monitor, Human Fertilisation and Embryology Authority and the Commission for Patient and Public Involvement in Health (CPPIH).

Task 8: To scrutinise major appointments made by the Department

40. The Committee has not held evidence sessions specifically to examine appointments, but we have taken evidence from senior officials shortly after their appointment. Prior to his early retirement in March 2006 Sir Nigel Crisp was both Permanent Secretary of the Department and NHS Chief Executive. He had two successors. Sir Ian Carruthers took over as acting Chief Executive of the NHS and Hugh Taylor became Acting Permanent Secretary of the Department. We took evidence from Sir Ian Carruthers in April 2006 and Hugh Taylor in April and November 2006.[13] Subsequently David Nicholson took over from Sir Ian Carruthers as the NHS Chief Executive on 27 July 2006. We questioned him as part of the *PEQ* inquiry in November 2006.[14]

13 Fourth Report of the Health Committee, Session 2005-06, *Independent Sector Treatment Centres*, HC 934-III, Q528-616; Oral evidence taken before the Committee on 29 November 2006, HC 94-ii

14 Oral evidence taken before the Committee on 23 November 2006, HC 94-i

Task 9: To examine the implementation of legislation and major policy initiatives

41. Task 9 has been a major part of our work in this session. Both our inquiries into *NHS Deficits* and *Workforce Planning* have considered the history of major policies since 1999, in particular the implementation of the NHS Plan 2000. We were surprised to discover that figures for staff growth had massively exceeded the Plan; for example, 80,000 more nurses had been employed that the Plan had envisaged.

42. Our inquiry into *ISTCs* also addressed Task 9. The first treatment centre where elective surgery was carried out and emergency surgery was excluded was established in 1999. In 2002 the Government announced a programme of NHS Treatment Centres. At the end of 2002 the Government started to commission treatment centres from the independent sector. In our *ISTC* Inquiry we examined both elements of this policy. We were convinced that the separation of elective and emergency surgery provided major benefits; on the other hand, we were not persuaded that independent sector undertook the task more effectively than NHS centres.

43. The Committee has kept a close watch on the implementation of policies which have been adopted as a result of its recommendations. In the last Parliament the Health Committee published a report on *Venous Thromboembolism*. The report had the support of the relevant royal colleges and the Government agreed to implement the main recommendations, including the establishment of appropriate committees in hospitals. NICE had planned to produce guidelines; as a result of the Committee's inquiry, the Government commissioned NICE to produce broader guidance to include more patients who might be at risk.[15] When the draft guidelines were published the Committee wrote to the Secretary of State with some concerns and asked whether the Department had fully considered the work of the independent expert working group. The Government is to publish the report of the expert working group and involve NICE and others in developing VTE risk assessment.

44. In 2003 we published a report on *Sexual Health*.[16] The Government accepted a number of our recommendations to cope with what we described as a serious crisis. In 2005 we held a further inquiry to examine their implementation of policy. The reply was published in this Parliament.[17] Since some of commitments had still not been fulfilled, we sought and were granted a debate in Westminster Hall on the subject in February 2006.[18]

45. We have also taken a continuing interest in child migrants. In 1998 we published a report on the children who were sent to Australia and other Commonwealth countries between the 1940s and 1960s where many suffered severely.[19] We were pleased that the Government accepted our main conclusions and recommendations and acknowledged the

15 Second Report of Session 2004–05, *The Prevention of Venous Thromboembolism in Hospitalised Patients*, HC 99, and the Government Response, Cm 6635

16 Third Report of Session 2002–03, *Sexual Health*, HC 69–I

17 The Government response to the Health Select Committee's Third Report of Session 2004–05, *New Developments in Sexual Health and HIV/AIDS Policy*, Cm 6649

18 HC Deb, 9 February 2006, Col 323WH

19 Third Report of Session 1997–98, *The Welfare of Former British Child Migrants*, HC 755–I

responsibility of British Governments for the children's suffering. In particular, it agreed to fund the Child Migrant Trust which helps former migrants make contact with their families. Unfortunately, in 2003 responsibility for this issue was transferred from the Department of Health to the Department for Education and Skills. Subsequently, the funds to the trust were cut and its funding was to be removed entirely from March 2007. We wrote to the Secretary of State for Education to find out why. The reply was initially unsatisfactory so we decided to undertake a short inquiry, holding an evidence session with Department of Health and Education Ministers.[20]

20 Fortunately, before the evidence session took place, the Government agreed to reconsider the funding of the Trust. Accordingly we decided to postpone the evidence session and await further developments.

Objective D: To assist the House in debate and decision

Task 10: To produce reports which are suitable for debate in the House, including Westminster Hall, or debating committees

46. The Committee's reports have been regularly debated in the House and Westminster Hall. Estimates Day debates were held on the Report published in the last Parliament on the *Influence of the Pharmaceutical Industry*[21] and on deficits in the NHS based on the oral and written evidence we took on *Public Expenditure* in 2005.[22] There were also Westminster Hall debates on the *Changes to Primary Care Trusts* Report and the *New Developments in HIV/AIDS and Sexual Health Policy* Report.[23] The Committee has bid for Westminster Hall debates on two Reports published in this Session, *Independent Sector Treatment Centres* and *NHS Charges*.

47. Our reports and the evidence taken before the Committee are also frequently referred to in Health Questions and in other debates on health in the House and in Westminster Hall. A number of the reports have influenced important debates in the House. The report on *Smoking in Public Places*, which was tagged to the Report and Third Reading debate of the Health Bill, was, as we have seen, the most influential.

21 HC Deb 8 December 2005, Col 1021. The report was the Fourth Report of Session 2004–05, *The Influence of the Pharmaceutical Industry*, HC 42–I, published on 5 April 2005

22 HC Deb, 20 March 2006, Col 76

23 Third Report of Session 2004–05, *New Developments in HIV/AIDS and Sexual Health Policy*, HC 252–I

Innovations in Working Methods

48. Since the General Election the Committee has introduced a number of innovations in its working methods. First, it decided to publish written evidence when possible at the beginning of an inquiry. This means that the written evidence is available in one volume, and on the Committee's webpage, before the first oral evidence session.[24] The Committee has continued this exercise for almost every inquiry since.[25] The practice has several advantages. Evidence is available in one relatively slim volume which is much easier to use than the bulky photocopied memoranda which would otherwise have to be dragged around. In addition, witnesses are able to see what evidence each of them have submitted, which stimulates further discussion and comment. It was a pleasure to see the Secretary of State, the Permanent Secretary and the Director of Finance arrive for an evidence session on the *PEQ* with well-thumbed copies of the evidence.

49. Another innovation has been the informal meetings with the Chairman on Mondays, and to which other members of the Committee are invited. In total the Chairman has held over 70 such meetings since the election. They provide an excellent opportunity for organisations in the health sector to raise concerns about current health policy. The Chairman has met many of the Department's Arm's Length Bodies (see paragraph 39), Royal Colleges, Unions and NGOs working in the health service. The Chairman also met members of the National Youth Parliament who had carried out a consultation amongst school children regarding the teaching of sexual health.

50. The *PEQ* exercise generates a large amount of information from the Department, much of it in the form of tables. These are provided to the Committee by the Department as spreadsheets. In the past, while the information was published, the spreadsheets were not available to the public which restricted their ability to manipulate it. This year the Committee placed the spreadsheets on its website.[26]

24 See our First Report of Session 2005–06, *Smoking in Public Places*, HC 485–I. The deadline for written submissions was 14 September, the volume of written evidence was published on 19 October and the first oral evidence session was on Thursday 20 October 2006.

25 The exception being *Changes to Primary Care Trusts* where it was not possible as the Committee announced the inquiry on 21 October and held the first oral evidence session on 3 November 2006.

26 See www.parliament.uk/healthcom

Impact of the Work of the Committee

51. The Committee makes an impact in a variety of ways. Most obviously, it affects policy. As we stated here already, our report into *Smoking in Public Places* seem to have played a part in the House's decision to amend the Health Bill and introduce a comprehensive smoking ban (see paras 14–18).

52. Sometimes changes in policy take place during an inquiry. During our inquiry into *ISTCs* the Government announced its intention to encourage private providers to train doctors and to integrate better with the NHS.

53. The Committee acts as a forum where major health issues are aired. Prominent this year were the causes and consequences of the deficits and the mistakes made in workforce planning in recent years. Senior figures are questioned about both the most topical and neglected subjects: Ministers, senior DoH officials, heads of arms length bodies, clinicians including heads of royal colleges and representatives of nurses and other professionals, chief executives, chairmen of trusts and academics, as well as patients, individual practitioners and managers who were able to provide a very different version of events from the Department's. The Committee is able to establish the truth. For example, the need for additional capacity has often been given as the justification for ISTCs; our questioning revealed that the additional capacity had been too small to have a significant effect.

54. The Committee's inquiries also act as a way of publishing important information. The *PEQ* is particularly valuable in this regard, providing a wealth of economic information, much of which is unavailable elsewhere, in one document. Sometimes it is important to reveal the extent of ignorance. For example, the Royal College of Nursing did not know what the extra 85,000 nurses employed since 1997 were doing.[27] Similarly, the Government has employed 45% more people in central administration since 1997, which includes clerical workers and people in human resources, but has no idea how the figure breaks down and what the additional staff are doing.[28]

27 Oral evidence taken before the Committee on Thursday 18 May 2006, *Workforce Planning*, HC 1077-ii, Q 167

28 Oral evidence taken before the Committee on Wednesday 29 November 2006, *Public Expenditure on Health and Personal Social Services 2006*, HC 94-ii, Qq 156-157

Annex 1 Subjects covered by the Health Committee in 2005–06

Subject	Evidence Sessions	Outcome
Smoking in Public Places	3	Report, December 2005
Changes to Primary Care Trusts	2	Report, January 2006
NHS Charges	4	Report, July 2006
Independent Sector Treatment Centres (ISTCs)	5	Report, July 2006
Workforce Planning	8*	Written evidence in May 2006 Oral evidence in May & June 2006; report expected in 2007
NHS Deficits	5**	Report, December 2006
Public Expenditure 2005	2	Written and Oral evidence in December 2005
Public Expenditure 2006	2	Written and Oral evidence in December 2006

*Five in Session 2005–06 and three in Session 2006–07

** Four in Session 2005–06 and one in Session 2006–07

Annex 2 Visits by the Health Committee in 2005–06

Location	Date	Purpose of visit
Dublin, Ireland	October 2005	Smoking
Cardiff, Wales	February 2006	NHS Charges
Stockholm, Sweden	March 2006	NHS Charges and Independent Sector Treatment Centres
Redwood Diagnostic and Treatment Centre, Surrey, Will Adams NHS Treatment Centre, Gillingham, Kent, and Woodland NHS Treatment Centre, Darent Valley Hospital, Dartford	April 2006	Independent Sector Treatment Centres
San Francisco, USA	May 2006	Workforce Planning
Ljubljana, Slovenia	November 2006	Cancer seminar*

* Representative travel by the Chairman

Formal minutes

Thursday 1 February 2007

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Stewart Jackson
Charlotte Atkins	Dr Doug Naysmith
Mr Ronnie Campbell	Dr Howard Stoate
Jim Dowd	Dr Richard Taylor
Sandra Gidley	

The Committee considered the draft Report [The Work of the Committee in 2005–06], proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 54 read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

[Adjourned till Thursday 8 February at 9.30 am

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)

Third Report	Delayed Discharges	HC 617 (Cm 5645)