PARLIAMENTARY DEBATES
HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

HEALTH AND SOCIAL CARE BILL

Sixth Sitting
Tuesday 15 February 2011
(Afternoon)

CONTENTS

Clause 1, as amended, agreed to.
Adjourned till Thursday 17 February at Nine o’clock.

PUBLISHED BY AUTHORITY OF THE HOUSE OF COMMONS
LONDON – THE STATIONERY OFFICE LIMITED
£5.00

PBC (Bill 132) 2010 - 2011
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The Committee consisted of the following Members:

**Chairs:** MR JIM HOOD, †MR MIKE HANCOCK

† Abrahams, Debbie *(Oldham East and Saddleworth)* (Lab)
† Barron, Mr Kevin *(Rother Valley)* (Lab)
† Blenkinsop, Tom *(Middlesbrough South and East Cleveland)* (Lab)
† Brine, Mr Steve *(Winchester)* (Con)
† Burns, Mr Simon *(Minister of State, Department of Health)*
† Burstow, Paul *(Minister of State, Department of Health)*
† Byles, Dan *(North Warwickshire)* (Con)
† Crabb, Stephen *(Preseli Pembrokeshire)* (Con)
† de Bois, Nick *(Enfield North)* (Con)
† James, Margot *(Stourbridge)* (Con)
† Kendall, Liz *(Leicester West)* (Lab)
† Lefroy, Jeremy *(Stafford)* (Con)
† Morgan, Nicky *(Loughborough)* (Con)
† Morris, Grahame M. *(Easington)* (Lab)
† Poulter, Dr Daniel *(Central Suffolk and North Ipswich)* (Con)
† Pugh, John *(Southport)* (LD)
† Shannon, Jim *(Strangford)* (DUP)
† Smith, Owen *(Pontypridd)* (Lab)
† Soubry, Anna *(Broxtowe)* (Con)
† Sturdy, Julian *(York Outer)* (Con)
† Thornberry, Emily *(Islington South and Finsbury)* (Lab)
† Turner, Karl *(Kingston upon Hull East)* (Lab)
† Twigg, Derek *(Halton)* (Lab)
† Wilson, Phil *(Sedgefield)* (Lab)

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 15 February 2011

(Afternoon)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

4 pm

The Chair: Good afternoon. I have spoken to a Clerk in the Ways and Means office, and he has left it to me to use my discretion on the matter of coffee. Therefore, I have said that we can have coffee in the Committee, although hon. Members will have to persuade Mr Hood of that, and I expect the Clerk will report me to the appropriate House authority for a good caning. However, we will allow coffee during the sittings, which will be a first for a Public Bill Committee.

Clause 1

THE SECRETARY OF STATE AND THE COMPREHENSIVE HEALTH SERVICE

Derek Twigg (Halton) (Lab): I beg to move amendment 35, in clause 1, page 2, line 8, at end insert—

'(d) NHS providers and providers to the NHS.'.

Thank you, Mr Hancock. I hope your decision does not exclude tea—a fine English tradition.

The amendment’s purpose is twofold: we seek to tease out from the Minister assurances about accountability and how committed the Government are to maintaining services. Will the Bill create a big distance between the Secretary of State and the provision of services? I will not go into positions of the commissioning board and the GP consortia, but they are obviously an important part of that.

When we discussed amendment 32, it was stated that there would be no mechanism in the Bill to make the Secretary of State responsible for the provision of services. Perhaps the Minister will address that point. The amendment is designed to reinforce the idea that the Secretary of State is responsible for providing health services for the country, and one way to do that is by directly exercising his function in relation to NHS providers. That goes to the heart of a discussion that I know we will have again later.

A number of hon. Members asked whether hospitals might somehow be saved because of the Bill, and we will certainly explore that in more detail later. As for whether there will be no centrally directed closures, again, there are some interesting aspects to the Bill that relate to such matters. I am looking forward to debating whether hospital and accident and emergency unit closures and reconfigurations will somehow not happen because of what has been put in the Bill. Perhaps that is a debate for later on, but it is worth flagging up at this stage.

It is important to be clear about the key points. Whenever we refer to issuing the Secretary of State with certain powers or constructing guidelines with regard to NHS providers, we must also refer to providers to the NHS—in other words, independent or private providers seeking to provide NHS services. It is paramount that we place “NHS providers” and “providers to the NHS” on the same legal footing, to ensure that there is no ideological bias in favour of the private sector. That is important in terms of the role of the private sector in the provision of services which, if the Government get their way, will be affected by the commissioning board and the consortia. A crucial debate in the Committee will be on the role of Monitor and the powers that the Secretary of State will or will not retain over the provision of services.

As I have mentioned, there is a debate about the direct involvement of the Secretary of State in driving improvements in the NHS and responding to the concerns of hon. Members and the public about, for example, potential cuts. To return to the question of hospital reconfigurations, because of the Government’s financial decisions on the NHS and, if the House agrees, the decisions on the powers of Monitor, which will designate services, there may be cuts or closures. During the clause 4 stand part debate, it will be interesting to explore what powers the Secretary of State will exercise. Will he intervene in hospital closures if Members of Parliament seek to meet him and get his view? The involvement of the Secretary of State is very important, not only in driving through improvements but also in dealing with difficult decisions that affect our constituents and constituencies.

Under the Bill, the Secretary of State will not be able to exercise his function directly in relation to NHS providers to the NHS, or intervene to secure the provision of specific services in specific areas. That is our understanding—perhaps the Minister will say whether that understanding is correct. Instead, the Secretary of State will solely have the power to instruct the bodies set out in the new section 1(2A) of the National Health Service Act 2006 on how to act by, for example, setting the annual mandate for the NHS commissioning board, as the explanatory note mentions.

The annual mandate is another very interesting mechanism in terms of its impact on the NHS and the powers of the Secretary of State. If the Minister wants to say something about the mandate at this stage, we would be very happy to hear him. If he wants to say something later, we will be happy to hear it, because the mechanism is one that we need to explore as fully as possible.

The amendment is designed to ensure that the Secretary of State retains more of his current power to drive improvements in the NHS and to ensure that any decision is in the best interests of the people of this country and health service provision. In a sense, we have come to what is probably a difference between our two parties. We think that a Secretary of State with those powers is crucial to driving through significant improvements of the sort that we have seen since 1997, whether in the form of shorter waiting lists, improved cancer and coronary care, and so on, or better appointments with GPs. There has been a range of improvements, which I think the Minister tried to suggest in a previous debate amounted to political interference. Again, what is important for the Secretary of State to direct and what is political interference is a debate that I am sure we will continue to have throughout Committee stage, but we
Mr Burns: The short answer is no, not only because of what I have already said, but because, to put it in shorthand, the effect would be to redefine the Secretary of State’s role in relation to providers and to require him to have a direct role with them, which is not in the whole ethos and vision of liberating the NHS. I hope that the hon. Gentleman will come to appreciate and understand that it is important that we have a liberated NHS that can concentrate, as I said before, on raising quality standards and improving outcomes, which are the most important things for patients. They want to get better quicker, to be treated better and to have the finest health care.

Grahame M. Morris: I understand that the Minister is not willing to be drawn on some of the issues that I raised about private sector competition in the new structure, but may I refer him to the evidence given by the British Medical Association, which is clear about its concerns? Although it welcomes further clinical involvement in commissioning, which is certainly contained in the Bill, the positive aspects of the Bill are threatened by other unnecessary reforms, which, from its perspective, include the involvement of the private sector and any cherry-picked certain types of health care provision, which were given contracts that paid them more than the NHS for the same operations. The contracts also had a rather perverse condition that, if the provider was contracted to provide 100 cataract operations a day and it provided only 50, it was still paid for 100, which seems rather uncompetitive. However, as I think you will agree, Mr Hancock, I will not go down that route at this stage, simply because that debate does not altogether come under the clause. There will be more than ample opportunities under the right part of the Bill to discuss the question of a level playing field in greater detail. I am sure that the three Opposition Front Benchers are looking forward to that avidly. We will be able to correct some of their misunderstandings and misapprehensions.

As I was saying, we want patients to have choice in where they are treated, from whichever provider offers the best quality at NHS prices. That includes private voluntary organisations, as well as traditional NHS providers. Patients already have a free choice of provider for elective procedures, and we want to build on that by extending choice into other areas of care.

Owen Smith (Pontypridd) (Lab): Does the Minister not see some value in inserting the amendment as drafted, to offset the risk that we might have a significant change in the make-up of NHS providers over time, with more and more private or non-traditional providers coming in, and with unintended consequences? I offer that in the spirit of it being a safeguard against any such unintended consequences, and I am sure that the Minister does not want to see the NHS predominantly run out of the private sector.

Mr Burns: I will be very careful in responding to that question, not because I do not want to, as I certainly do. For example, under the Bill we will stop the perverse and uncompetitive practices relating to independent sector treatment centres. As the hon. Gentleman will recollect, they were independent sector providers that cherry-picked certain types of health care provision, which were given contracts that paid them more than the NHS for the same operations. The contracts also had a rather perverse condition that, if the provider was contracted to provide 100 cataract operations a day and it provided only 50, it was still paid for 100, which seems rather uncompetitive. However, as I think you will agree, Mr Hancock, I will not go down that route at this stage, simply because that debate does not altogether come under the clause. There will be more than ample opportunities under the right part of the Bill to discuss the question of a level playing field in greater detail. I am sure that the three Opposition Front Benchers are looking forward to that avidly. We will be able to correct some of their misunderstandings and misapprehensions.

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4.15 pm

Mr Burns: I do not want to test your patience, Mr Hancock. We will, at a later—and, I would argue, more appropriate—stage, be able to discuss the whole area of any willing provider and competition in far greater detail. I assure the hon. Gentleman, as I did the hon. Member for Pontypridd, that we will give a full explanation and we will be able to show how this flows naturally from what the previous Labour Government started.

Jeremy Lefroy (Stafford) (Con): I am somewhat puzzled by the point that the Opposition make in the amendment. I refer to the National Health Service Act 2006, where under section 8:

“The Secretary of State may give directions to any of the bodies mentioned in subsection (2),”

which are

“(a) Strategic Health Authorities,
(b) Primary Care Trusts,
(c) NHS trusts, and
(d) Special Health Authorities.”

Foundation trusts, which are indeed providers, are not mentioned there.

Mr Burns: Indeed, my hon. Friend hits on a crucial point, because of course he knows as well as I do—as, I suspect, do Opposition Members, although they may not be quite so keen to remember—that the whole purpose and principle behind foundation trusts was to give them independence from the controls and the day-to-day micro-management that the other providers in the NHS still have from the Secretary of State and other Ministers in the Department of Health. They have that independence because Tony Blair recognised, as did Alan Milburn, that there were great advantages for the advancement and improvement of patient care and quality in having providers that had a degree of independence to get on with developing the quality care that they wanted to provide for patients.

Grahame M. Morris: Will the Minister give way?

Mr Burns: No, the hon. Gentleman has had his turn. I am bringing my remarks to a conclusion, simply because we could be here until Christmas—if the programme allowed it—if we carried on at this pace.

Creating new powers over providers would simply be turning the clock back to a view of the NHS as some kind of nationalised industry that should be managed from Whitehall. That is certainly not what the Government want. I do not know how many Opposition Members do not want that sort of NHS, but I know that in 2002-03, when the first wave of legislation was introduced to begin liberating the NHS, it was driven on a principle that was probably best enunciated by the then Secretary of State for Health Alan Milburn to the Social Market Foundation, when he said,

“the NHS cannot be run forever like a 1940s-style nationalised industry.”

He was right then, and fortunately he put in process the procedures to start to modernise the NHS. We watched with great interest the progress of modernisation under the rest of the Blair Government, and the Government of the right hon. Member for Kirkcaldy and Cowdenbeath (Mr Brown), and we are now building on what Tony Blair and Alan Milburn wanted to achieve.

Liz Kendall (Leicester West) (Lab): The Minister may also want to quote comments that Alan Milburn recently made to the columnist Polly Toynbee, where he directly refuted the suggestion that this was a continuation of his policy. He said that there had always been a managed system under Labour and that the current Government’s policies would lead to chaos. He directly refuted that statement, so perhaps the Minister might not be quite so selective with his quotes in future.

Mr Burns: No, I can reassure the hon. Lady that that I am not selective at all. I was giving a direct quote, which was the full sentence—I was not halving a sentence—in the context of the speech that Alan Milburn gave at that time.

Emily Thornberry (Islington South and Finsbury) (Lab): Will the Minister give way?

Mr Burns: No, I will not, because I am explaining to the hon. Member for Leicester West. In a way, she has taken what Alan Milburn said the other day out of context. She failed to say why he was opposed to this aspect of our reforms, and what he said was based on a total misapprehension and a myth that has been perpetuated by Labour Members and their allies in the trade unions.

Liz Kendall: You do not think that he is clever enough to have read the Bill himself?

Mr Burns: I do, but I also know that he is an accomplished and clever politician. Accomplished and clever politicians such as Mr Milburn will use arguments as they wish to help their colleagues in the House of Commons. The main thrust of his criticism was on one specific area, and I am afraid that he was wrong on that—it is a myth. My hon. Friend the Minister of State and I will demonstrate that when we get to the section of the Bill that deals with competition, which slightly locks in with the interventions made by the hon. Member for Easington. The hon. Member for Leicester West knows what I am talking about because she used to be a special adviser at the Department of Health. I assure her that Mr Milburn is under a misapprehension and we will try to convince her. However, I am beginning to think that despite the generosity of the hon. Member for Halton, and the honeyed words that he uses every time he moves an amendment, his mind is closed when it comes to persuasion.

Mr Kevin Barron (Rother Valley) (Lab): When Alan Milburn left the Government, he was one of the first persons on the Labour side to say that we should have directly elected members of primary care trusts. Is the Minister saying that Alan Milburn supported the abolition?

The Chair: Order. Leave Mr Milburn out of this. It is not taking us anywhere, and if we are going to go backwards and forwards about what he did or did not say, when he said it and who he said it to, I do not think we will progress very far. I know that you, Mr Burns,
like to be fair in spreading yourself around on these criticisms of former colleagues, but I think it is better that we move on.

Mr Burns: Mr Hancock, as always, you are absolutely right. To spare Opposition Members from further blushing, I will cease to mention Mr Milburn. I will say to my hon. Friends that the amendment would not do what I would want it to do. It is not compatible with the vision and the ethos of the modernisation programme, and would be a deterrent to moving forward rather than an advancement. If the hon. Member for Halton were to press it to a Division, I invite my hon. Friends to join me in voting against it.

The Chair: I would very much like Mr Twigg not to reply on behalf of Mr Milburn, but to speak to his amendment.

Derek Twigg: As always, I will take your guidance to the letter, Mr Hancock, and I will not mention that person again.

The Minister, in some ways, slights me. Some of the amendments may turn out to be probing amendments, or may be ones that Members want to vote on. I have given the Minister the chance to persuade me and my colleagues that we may have misunderstood the Bill in some way. He has reassured us that the aims are somewhat different from what we think they are, but he did not answer the key question about the change in direct responsibility for providing and securing the provision of health services. The Bill will change that completely—it will be a fundamental and major change. He dressed that up with an argument about political interference, but he was never able to articulate or explain what that meant. We had, for instance, three examples of interference in an earlier debate.

In fact, we could go back to the debates at the start of the health service and the Conservative party’s position at the time regarding political interference in the running of the services. We seemed to have come again to an argument from many years ago. Over many decades, the Conservative party—I am surprised that the Liberal Democrats are going along with this—has generally supported the national health service and the current provision of those services by the health service and the Secretary of State.

However, the Minister is now arguing for a major change that he has not explained. What evidence is there that making the change will improve health services? What evidence is there that things can be done better this way? How does he answer the point about the Secretary of State’s role in ensuring that the organisations responsible for providing the services will act in a similar way to the Secretary of State in terms of overall concern for public need? The Minister has not outlined those issues. It is a fundamental change to the health service, and the only answer that he seems able to give is that it will reduce political interference. He has not been able to give any evidence to support such a major change.

I ask the Minister again. I am not sure that I will get very far, but it is worth putting it on record that we tried. We are seriously concerned about fragmentation, lack of collaboration and serious damage to the provision of health services if the clause is passed.

Mr Burns: I will respond briefly. The trouble is that the hon. Gentleman, I suspect for philosophical reasons, does not accept the basic premise that drives the reforms and what we are committed to. As he rightly says, all my political life I have been a staunch supporter of the national health service. I believe in it, I use it and I do not want it privatised. There is no intention whatever to privatisé it, and there never has been in any previous Conservative Government. We want to strengthen it.

However, the hon. Gentleman and I differ significantly about how to do so. I believe that the NHS must be modernised and evolve to go from strength to strength. That philosophy is based on a belief that we need to liberalise the national health service, with checks and balances, to ensure that providers get on with their job of providing quality health care for patients. It is a philosophical divide, I am afraid. Whatever I say, I fear that the hon. Gentleman will not accept it, simply because he wants to keep the status quo and stay within his comfort zone in his views on how the NHS should continue to run, rather than giving it the powers to aspire to bigger and better things by building on its strengths to improve and enhance quality and outcomes.

Derek Twigg: That seems to me to prove that the reforms are ideologically driven.

Mr Burns: No, they are not.

Derek Twigg: It seems clear. As for the idea that we are against modernisation, he talked about modernisation under Labour Governments—I shall not mention a certain person. Labour Governments have continually modernised the health services. It is not as though we have stood still and not improved the health service or made changes. Of course we have, and we have talked about those changes. To try to paint us into a corner and say that we are against modernisation and change is completely inaccurate and wrong.

This is the biggest shake-up of the health service since its conception. The cost is phenomenal, and the chaos it is causing and the potential damage to the health service are immense. That is the difference. This is ideologically driven. It is cast under the shadow of reducing political interference, but the Minister cannot explain what evidence backs up the proposals.

Grahame M. Morris: On the point about marketisation and the difference between these health reforms and the approaches of previous Governments, rather than an NHS in competition with itself, the BMA and others called for a co-operative and co-ordinated environment in which patients are guaranteed the most clinically appropriate and cost-effective care. Price competition in a fully open market would make that impossible.

4.30 pm

Derek Twigg: My hon. Friend makes a powerful point. The problem is that we are seeking reasons why the change is being made and analysis of what it will do in practice, and we cannot get them from the Minister. I can understand the reasons for that. I suppose that we could argue about this all day, but we will return to it in more detail during the stand part debate.
Mr Burns: I would like to quote something to the hon. Gentleman, as it gets to the nub of some of the points that he just made:

“I wondered—as did some of the newer and more radical faces in my Policy Unit, although this was still heresy in the party, not least among most of my ministers—whether we had been right to dismantle wholesale GP commissioning in the NHS...instead of adapting these concepts of local self-governance to spread decentralised management across the state health and education systems...I also chafed increasingly at the restrictions placed in the way of good independent providers establishing themselves within health, education and the other public services. This seemed to me a classic case of the confusion between means and ends which had dogged the left for a generation—and which it was New Labour’s mission to overcome. For public services to be equitable, and free at the point of use, they did not all need to be provided on a monopoly basis within the public sector, controlled in a rigid way by national and local bureaucracies often deeply resistant to innovation and genuine local autonomy.”

Those words, which are excellent and get to the nub of the matter, are not mine, sadly. They are Tony Blair’s, from his autobiography.

4.32 pm

Sitting suspended for a Division in the House.

4.46 pm

On resuming—

The Chair: Thank you all for coming back so swiftly. I ask Mr Twigg to decide whether to press the amendment to a Division or ask for it to be withdrawn.

Derek Twigg: I listened carefully to what the Minister had to say. I remain unconvinced, so I shall press the amendment to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 5]

AYES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Smith, Owen

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Sturdy, Julian

Question accordingly negatived.

Mr Burns: I beg to move amendment 1, in clause 1, page 2, line 13, after second ‘and’, insert ‘paragraphs 7C, 8 and 12 of’.

The Chair: With this it will be convenient to discuss Government amendments 2 and 3.

Mr Burns: I hope that we can deal with the amendments fairly swiftly because they are minor and technical. They clarify two things. The first is that research is not solely a public health function, but spans both public health and the NHS; secondly, they deal with the definition in clause 1 of local authorities’ public health functions.

Proposed new subsection (2B) of the National Health Service Act 2006 includes the expression “the public health functions of the Secretary of State” so as to include all of his functions under schedule 1 to that Act. That includes his power to conduct, commission or assist research under paragraph 13 of that schedule. One effect of this is that, in clause 5, the NHS commissioning board’s duty to promote the comprehensive health service excludes such activity. However, such research may relate to the NHS as well as to public health. It is therefore not appropriate to exclude it from the board’s duty to promote.

Amendment 1 has the effect of removing the research function from that definition. That has always been the Government’s policy, and the amendment does not represent any change to our stance on health research. We have always been of the view that the Secretary of State should foster research in both public health and the NHS.

Amendment 2 adds dental public health functions under section 111 of the 2006 Act to the definition in clause 1 of local authorities’ public health functions. Those functions are conferred on local authorities under clause 13.

Amendment 3 clarifies which provisions of schedule I to the 2006 Act confer public health functions on local authorities—namely, paragraphs 1 to 7B and 13. They cover the medical inspection of schoolchildren, the weighing and measuring of children, and research for health service purposes, all of which are conferred on local authorities under clause 25.

It is not merely a question of terminology. The amendments are necessary because the definition in clause 1 has implications later in the Bill. For example, clause 5 provides that the NHS commissioning board’s duty to promote the comprehensive health service does not apply to that part of the health service that is provided in relation to the public health functions of local authorities. It is for these reasons that I move that the amendments be made.

Derek Twigg: I wish to be clear about the Secretary of State’s powers in relation to research. If I heard him correctly, the Minister said that the commissioning board had responsibility. Will he clarify that? Is the Secretary of State’s power being reduced or changed, with the commissioning board taking over that responsibility? The Secretary of State has a duty for public health and health generally; I apologise if I misunderstood the Minister, but am not quite clear what he meant.

Mr Burns: I hope to be helpful. Through the amendments, I wish to ensure that research is not solely a public health function but is also a function of the NHS. The NHS commissioning board has a duty, and we want to tidy up the Bill’s provisions to ensure that the board has that power and responsibility.
Derek Twigg: Will the Secretary of State’s duty change in any way?

Mr Burns: No. Without the amendments, the Bill would preclude the Secretary of State from the NHS section. We want to draw it together so that he is responsible for public health and for the NHS.

Derek Twigg: The Minister mentioned clause 13. Would he expand on that a little? I am not clear where that takes us, in terms of what the public health responsibilities are now and what they will be under the Bill.

Mr Burns: Clause 13 is referred to in amendment 2. It adds the dental public health functions of section 111 of the 2006 Act to the definition in clause 1 of local authorities’ public health functions. I hope that I have helped the hon. Gentleman.

Amendment 1 agreed to.

Amendments made: 2, in clause 1, page 2, line 15, leave out ‘section 2B’ and insert ‘sections 2B and 111’.

3, in clause 1, page 2, line 16, after ‘and’, insert ‘paragraphs 1 to 7B and 13 of’.

Question proposed, That the clause, as amended, stand part of the Bill.

Derek Twigg: I think this debate will be very useful, particularly for many of my hon. Friends, in getting our concerns and points across. I want to set the scene and ask the Minister a number of questions, which will be a bit more detailed than those I was allowed on the specific amendments. They will speak to the concerns that we have on the role and responsibility of the Secretary of State, transparency and accountability, and the responsibility for the provision of services, which we have already had some debate on.

It is important to make the point that democratic accountability is the cornerstone of our democracy. In its current form, the Bill raises serious questions on accountability, which have not been satisfactorily answered in debate on the amendments. In this debate, we will focus on those areas in particular.

As we know, the NHS is the single largest state organisation, and is paid for by our taxes. It is important that the service can be fully provided. Our health is all-important to us. The NHS is a safety net that ensures that we do not have to worry about how we will afford health care. It is the very principle that underlies the health service and some of our concerns on where it is going into the future, if these changes take place. Will that still be the case? The Minister will have a chance later to try to reassure us again.

It is important that those who run the service are accountable through the people to Parliament. To imagine that such an organisation could exist without the Secretary of State would go against the founding principles of the NHS. The issue about its being a national health service is very important. That is why we have concerns about the proposed changes that the Government are making to the Secretary of State’s responsibilities.

The reason for the shift to reducing accountability seems clear to us. As we know from this clause, this Bill is ideological. Public accountability is not needed if there will be a completely free market. I will come back to that issue in a minute. That is the driving principle of the Bill and the Minister has not—in any way—satisfied our concerns during the discussion of this clause. Our concern is whether the best possible care for everyone can be secured everywhere that health care is provided, with the change in the Secretary of State’s responsibilities.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Does the hon. Gentleman agree that one of the fundamental problems of the system is accountability, which the Bill seeks to address by improving it, but at a much more local level?

Derek Twigg: I have no doubt that we all want to see improved accountability, which is very important at local level. We could have another debate on commissioning and whether it should involve not only GPs, but other commissioners, local authority representatives, patient groups and so on. When we talk about accountability, we have to be careful to identify what we actually mean. The Government go one way, but during Committee stage, we will table amendments that will help to improve accountability. I do not want to go on to the PCT-consortia debate too much, but it comes back to PCTs. Could they not have been made more accountable, with more commissioners or by having patient groups or local councillors on the board, rather than going through wholesale change? The accountability of consortia, in particular to patients, is an important aspect of the Bill that we have yet to explore, because there are many concerns about how it will work. The hon. Gentleman makes an important point, but it is not as clear as he is suggesting in his questions.

5 pm

Grahame M. Morris: On accountability, in view of the reports in today’s newspapers on failures in the service for care of the elderly, which the Health Committee discussed this morning, does my hon. Friend think that the new arrangements will make any difference to the vertical or integrated lines of dealing with complaints and failings in the service?

Derek Twigg: Lots of concerns have been expressed about care and by post-care groups. I am sure that we will get into that later in our proceedings.

What we must not lose sight of is the fact that we all want to improve the health service and to achieve the most efficient and best possible value delivery of services that also meet the needs of patients. My argument is that the Bill will not deliver that in a way that we think it can be delivered, building on the improvements that Labour has made over the past 10 to 13 years. We will debate that later.

One of the problems with the Bill, which I pointed out in speaking to the first amendment, is its complexity, with a great deal of uncertainty about what the changes will mean in practice, as well as the interlinking between the powers of the Secretary of State, the commissioning board, the consortia, Monitor and healthwatch bodies—I could go on. There are lots of complexities, which is why I said that we want to spend some time on clause 1, because it is a fundamental part of the changes.
Many experts on health told us that they did not understand what the Bill meant or how it will work in practice, on the ground, in terms of responsibilities, accountability and transparency, so it is only right that we tease answers out of the Minister. His greatest argument is that he wants to reduce political interference, but he has not yet provided the reasons for making the changes, which are profound and have far-reaching implications.

Margot James (Stourbridge) (Con): That is not the first time today that the hon. Gentleman has cited organisations within the health service criticising the reforms, be they professional organisations, royal colleges or trade unions. Looking back over the past 20 years, I have trouble identifying a single set of reforms that those same organisations greeted with acclaim. With the possible exception of the 1997 reforms, reforms to the service, whether by Labour or Conservative Governments, have always garnered criticism and accusations of privatisation and such like. The foundation trust proposals were greeted the same way.

Derek Twigg: That is indeed true of any reforms over the years, going back to the setting up of the health service and the massive difficulties between the BMA and the then Secretary of State, Aneurin Bevan. Their exchanges were infamous for their bitterness. From the very inception of the NHS, there have been concerns about changes in health care.

The Government suggested that there was wholesale support for the principle of what they are doing, but when the Bill was published—before that as well—suddenly people were saying, “What does this mean?” and great concern was expressed. Some complained that the Government were putting about acceptance of the principle as a good way forward, because we are all in favour of commissioners being involved in commissioning, but that was not true. In fact, I cannot recall such a wide range of concerns expressed in recent times about a profound change, and the change the Bill represents is profound—it is the biggest single change. We must be careful about what we mean. I accept that any reform or change is likely to have a lot of opposition, but we are talking about the context and I must not stray too far from the clause, or I will be pulled up. However, the principle is important.

Going back to the complexity of the Bill, we want the Government to answer some of our questions. Further down the line, those answers will be very important for their arguments that the changes are not privatisation or whatever else the Minister is being accused of. He will have to explain the reasoning and the rationale behind some of these changes and what they mean in practice for the delivery of services.

On that point, during a debate with me on “Newsnight”, the Minister said on the record that we will have a fully open market in the NHS. That will clearly bring major challenges in public accountability. That brings us back to our earlier amendment on the provision of services. As he said, the fundamental change that there will be, as he said, a fully open market is something we want to explore.

Mr Burns: Genuine, I said.

Derek Twigg: Well, a genuine open market. I apologise if I got the word wrong. The Minister said a genuine market.

There are still lots of unanswered questions about the Secretary of State’s powers in public health. He is ceding so much power to Monitor, the NHS commissioning board and commissioning consortia that it seems clear to us that the Secretary of State wants to shield himself from the accountability associated with his own reforms, which is extremely worrying. Again, that is something we want to explore with the Minister.

The explanatory note is very clear about the changes in terms of revision:

“The Bill... draws a distinction between the Secretary of State’s public health functions and his role in relation to the securing of services for the purposes of the NHS. Currently, the Secretary of State is directly responsible for providing or securing the provision of all health services as set out in the NHS Act, a function which is largely delegated to Strategic Health Authorities and Primary Care Trusts (PCTs).... However, the new commissioning structure proposed by the Bill means that this would no longer be the case.”

As I said to the Minister, he really needs to be clearer. I sought an explanation using a quote from Tony Blair, but that does not really explain this. He has not stated what evidence the Government have for making this structural, profound change in going to consortia. He has not provided evidence of how that will make things better. I will come back to examples in a short while.

Mr Burns: I want to explain once again to the hon. Gentleman that the ethos behind the White Paper and the modernisation is that we want to detach, for want of a better word, the day-to-day micro-management of the NHS by Ministers and civil servants in Whitehall. We are creating the national health service commissioning board to do that. That board will drive the commissioning of health care.

The Secretary of State will issue a mandate that tells the commissioning board what we expect it to deliver in health care for the people of England. That will be done with checks and balances to ensure that that is delivered. However, what will be different is that it will not be Ministers doing the day-to-day managing and controlling; it will be the commissioning board within the remit given to it by the mandate, which is a far more transparent and accountable system. That is added to by the fact that the Secretary of State will have to produce an annual report to Parliament.

Derek Twigg: I apologise if it is me, but I still have not seen the evidence for this change. The Minister talked about checks and balances. Perhaps he might tell us what they will be. The fact is that he has not really explained why the Secretary of State should act only “with a view to securing the provision of services.”

The word “view” is used in the Bill. Why use that phraseology? Will he explain that to us, because it is an important part of what the Government are proposing?

For the record, I ask the Minister to set out clearly for the Committee the powers and responsibility of the Secretary of State. How do I work out what will happen on the ground if the Bill is passed? By way of explanation, let me try to help the Minister with some examples, which I hope he will take in the spirit of being helpful. It would be useful to have more explanation about the
mandate in respect of the national commissioning board and how he sees that working. On hospital closures and reconfigurations, which a number of his hon. Friends have raised, I am asking what, in practical terms, will be the impact of the powers of the Secretary of State and his accountability when real things happen in the health service, which is what we are all interested in? That is what our constituents are interested in: their hospitals, their GP surgeries and smoking prevention programmes are all important.

Let us take hospital closures and reconfigurations. Many Government Members are strongly of the view that the Bill will somehow stop a lot of the closures of hospital units and A and E units. The Government keep using the phrase, “no centrally directed closures,” but that does not mean that there will be no closures. Can the Minister tell me what the difference will be in the Secretary of State’s powers proposed in the Bill?

Let me give the example of MPs being able to lobby the Secretary of State, or indeed the Minister, who actually listens when issues are raised. He has been kind and helpful in a couple of cases in my constituency. How will the Bill change that? Take the example of the burns review, which was not about the Minister but about burns units in the north. There was a great deal of public anxiety and opposition; tens of thousands of people signed a petition, and there were real worries about valued services being lost or transferred. As a group, the Merseyside MPs were able to lobby both a Minister of State and the Secretary of State about the closures. In the end, we were grateful that we won a victory and stopped the proposals being carried forward.

**Mr Burns: When?**

**Derek Twigg:** Two or three years ago. I would like the Minister to explain whether that will change. If I went to the Minister now, would he say, “I am sorry, but I can’t do anything about it. I have no powers. I will listen to what you have to say, but that will be the end of the story,” or will a Minister still be able to do something as a result of the powers in the Bill?

That is important in terms of accountability to Parliament. MPs who have a big health issue in their constituency want to have access to the Minister and to be able to talk to him about problems. Will that still be the case, or will the Minister say, “I am sorry, you have to talk to Monitor.”? It is important that the Minister tells us whether MPs will be told to go to Monitor, the national commissioning board or even local consortia to sort out health problems in their constituency.

It appears that because of the open market, the regulator’s powers make the Secretary of State powerless to act in, for example, designation of a service. Under the Bill, Monitor will have the power to designate services. What impact will that have on the Secretary of State’s involvement? In some mysterious way, the regulator will ensure that vital services are maintained, while the rest will be up to various competing organisations. The Secretary of State will have no role. How will he be accountable for quality standards, and what actions will he take as a result of the changes in the Bill? How will he ensure that there is no fragmentation of services? That is a key concern about the changes proposed in the Bill. What powers will the Secretary of State have to ensure that services are not fragmented and that collaboration takes place, so that we get the best possible value and delivery of health services in the future? Our concern, as the Minister knows, is that that will be difficult because of the setting up of consortia, the powers of Monitor, the competition rules and so on. It is important that we know what the Secretary of State’s role will be.

Although I discussed this earlier and the Minister gave an answer, I want to clarify it again for the record. Data and statistics are currently produced centrally by the Department of Health and can be accessed by MPs through parliamentary questions or by the public through websites. Will there be any diminution in the statistics and data on the health service under the changes proposed in the Bill, or, for example, will MPs with a question be told to go to Monitor, the national commissioning board or their local consortium? What will be the role of central Government in maintaining the statistics and data, which, of course, are essential and important for MPs when pursuing health issues? It is important that we get an answer to that.

5.15 pm

We cannot get away from the problems with the Bill. It will result in a massive reorganisation, and a great deal of concern and fear has been expressed by the health community about its implications. The general public do not understand the Bill, because it is very complex. The Minister has talked about changes and modernisation, but the health service has done pretty well with the modernisation that has taken place. The Labour Government were not going to stop there—we wanted to make more improvements—but the rationale for the present Government’s changes has not been explained.

Do not forget that the coalition and the Prime Minister have said that there will be no top-down reorganisations.

**Mr Burns:** That is an old chestnut.

**Derek Twigg:** The Minister says that, but it is a very clear statement. It is also in the coalition agreement. He has argued away the changes to PCTs, but can he explain what has changed over the past few weeks on there being no top-down reorganisations? The promise was, of course, made at a time when the NHS was improving. It had its highest public satisfaction rating and lowest work load and waiting times, and there was massive improvement in coronary heart disease and cancer care. Our amendments would place democratic accountability for the health service back with the Secretary of State, which, as I have said, I do not think the Minister has properly addressed.

I hope that we can have a full debate on that, because my hon. Friends have many concerns. I hope that the Minister can give us a clear explanation of what the proposed changes really mean for the delivery of health services on the ground and for the accountability of the Secretary of State both to the public and to Members of Parliament.

**Mr Barron:** My hon. Friend is absolutely right about the level of reorganisation that faces us. It is a massive reorganisation of the health service—certainly the biggest in my memory. I am a product of 1946 and there has
been nothing in this House on such a scale in the past 27 years. It comes from a Government who said in opposition that there would be no more top-down reorganisations of the national health service, and the Minister must accept that. In my role on the Health Committee in the previous Parliament, I shared platforms with the current Secretary of State when he said things such as that.

Although I accept and agree with some of the Bill’s intentions, the history of NHS reorganisation shows that it is not the answer to improving the national health service. It has not been the answer in the reorganisations that I have been involved with since becoming a Member of Parliament, and its history from the 1950s shows us that it is not the way to do it. Reorganisation has not stopped postcode prescribing; even the creation of the National Institute for Health and Clinical Excellence by the previous Government, to increase the rigour and discipline of the health service, did not stop postcode prescribing; and reorganisation certainly has not been able to improve best practice in our national health service.

Reorganisation does not change the culture. The lessons from the past show that it costs money and affects performance negatively in the short term. I am afraid that we are going to go through this while having to save the massive amounts of money that have been laid down for the NHS’s efficiency budgets. I will vote against clause stand part, because the measure is wrong. I do not disagree with the intention of it, but I think it is wrong.

In view of what you said earlier in this sitting, Mr Hancock, I will talk at later stages of our deliberations about the different commissioning bodies. We heard in the oral evidence session last week not only from the vested interests, but from people at the top such as Sir David Nicholson, for whom I have great respect, that people are confused, to say the least, about where the change in commissioning will take us. I genuinely believe that we should not have it, and I will go into some detail in our discussion of future clauses about the implications for my constituents and for people who work in the health service. I genuinely believe that this is a wrong step. It is based on what might happen. There have been many instances in which people have talked about national health service reorganisation and had very little to show for it five or 10 years down the road.

Finally, if the Minister wants me to get my Front Benchers to read out any of his speeches or the speeches of his right hon. and hon. Friends, I will be more than happy to lobby them. Let us listen to what he has to say about this reorganisation, not what ex-Ministers or ex-Members of Parliament have said. The real world is here and now. In my experience, it is out there. I keep in constant contact with wide areas of the national health service, and they fear what is going to happen. My difficulty with clause 1 is that no one knows what the outcome will be. We are moving into uncertain times, and it is the last thing that the national health service wants.

In the debate on the previous amendment, the intent behind both the amendment and the legislation eluded me. The hon. Member for Hallon seemed to suggest that the Secretary of State should have powers over not just NHS providers but providers to the NHS—powers over the suppliers of bedpans or whatever. The position of the Government was not as clear as one would wish it to be, either. Not accepting that amendment does not leave the Government free of a series of responsibilities and duties apropos NHS providers. The residual power is over estates, assets, functions and so on, and it is dictated by previous legislation. To say that we are liberating the NHS is a nice slogan, although the word “liberating” has an unfortunate history—Sudetenland and East Germany and other such places were liberated at one stage in their history.

What would really help is a degree of precision. If the Minister wrote to the Committee, spelling out precisely what his responsibilities are to NHS providers, as opposed to other sorts of providers who are outside the NHS, and what will remain after this the Bill is passed. The analogy of the foundation trust is helpful to an extent, but we have to bear in mind the expectation that PCTs will unravel as a series of social enterprises, which presumably differ in marked respects from hospital foundation trusts. Some organisations that should be foundation trusts will not be ready for such a status by the time the Bill completes its passage. Some organisations, such as special hospitals, have been examined and been found to be ill-qualified or inappropriate to be turned into foundation trusts.

The Minister will harbour a series of powers and responsibilities apropos NHS provider organisations. It would be very helpful if the Committee could have a note after this sitting spelling out what those powers are. None of us have a compendious and detailed knowledge of where existing legislation, which will remain in place, will leave us.

Owen Smith: The Minister stated very clearly that clause 1 and the debate about it go right to the heart, or the nub as he put it, of the ethos that the Government are trying to bring to bear in respect of the changes. I suggest that ethos is the word that we have been using today and not, as the Minister has suggested, evidence. There is a clear difference between an ethos and the evidence. We have heard lots about the ethos and very little about the evidence to support the conclusion that the changes he is seeking to introduce will effect the outcomes that he is looking for.

Be under no illusion, Labour members know precisely what the Minister and this Bill are about. It has been suggested several times today that we have not really got it over here. We understand entirely what it is about; we have heard the word “liberty” said repeatedly. The sweet bell of liberty has been ringing out all day. We get what that means. It is there in clause 1. It is about setting bits of the NHS free, starting with the Secretary of State. We start the ball rolling with the Secretary of State being effectively set free from his traditional duty to secure and provide services in the NHS—to treat people freely at the point of need—and instead we have this mealy-mouthed, weaselly phrase that he will act with a view to securing or providing. That is being presented today as a very minor change that we should not be concerned about: it is simply a reflection of the
reconfiguration that is envisaged, whereby the national commissioning board will be the bit of the NHS responsible for commissioning, the trusts will be responsible for providing services, and the consortia will be responsible for local commissioning. Therefore we do not need to worry about the Secretary of State because he will still be responsible and accountable through questions, and of course he will be providing this so-called mandate, which will not be political interference but instead will be an annual—an annual I do not know what exactly, because it is not clear in the legislation.

The point we have been trying to make throughout the day is that there is a very big difference between the NCB or the GP commissioning consortia having responsibility for determining the delivery of local services—being responsible for securing and providing—and the Secretary of State merely having responsibility to act with a view to securing them. I do not understand what “to act with a view to securing” means—it could mean anything. I ask the question—which I ask Members to consider seriously as it is not a frivolous point—what if the Secretary of State fails in this attempt to act to secure? What if the local bit of the NHS whose effective provision of health services he is trying to act with a view to securing cannot deliver in respect of either a particular service or a geographical area? Who is responsible for the failure of that group?

Liz Kendall: My hon. Friend will remember the evidence given to the Committee by David Bennett of Monitor, who was asked how services would be designated—that is, protected—to ensure continuous coverage. He said that they have yet to determine who was going to do that, or how, because they have not written the guidelines yet. The body that is perhaps responsible for these issues is saying to Parliament that it has not decided which services are guaranteed in an area like A and E, so how can we be asked to support this measure?

Owen Smith: My hon. Friend makes an extremely pertinent point—

Mr Simon Burns: indicated dissent.

Owen Smith: She does. It is bang on the money. The right hon. Gentleman may laugh but it is absolutely relevant, because we are being asked to take it on trust that the NCB and the GP commissioning consortia—and other aspects of this new configuration—will do their job correctly, and will secure and provide appropriate levels of services within new geographies. These will not be coterminous with traditional NHS formulae and, with respect, these are very complicated services.

The adjunct to the point about us not knowing precisely how those services will be designated is that we also had the chief executive-designate of the NCB telling us that they have a lot of work to do in respect of all other aspects of their work. He told us that directly. On our side of the House at least, there is very grave concern that we are stepping off the cliff into this uncharted area of reconfiguration with very little idea among the key people involved—Ministers, the chief executive, Monitor—about precisely how this will work. It begs the question of how hastily this has been rushed through.

The question of autonomy that we addressed right at the beginning is critical. As the Minister said, it sets the tone for the whole philosophical direction we are taking with the Bill. It is about, as we have heard, liberty—the Secretary of State is free not to be directly responsible for what he has traditionally been responsible for since 1948. We assume the National Commissioning Board will be free once it has its annual mandate to determine what the designated services are—we do not know what they will be or the role of the Secretary of State in eliciting from them the right sort of designation of services.

5.30 pm

The consortia, of course, are going to be free—autonomous as it says in the Bill. Another telling quote from an earlier iteration of the Bill, which was called the “Legislative Framework and Next Steps”, which says that the Government intend to “maximise the autonomy of individual commissioners and providers”. I think we have heard that very clearly today. The flip side of that was to “minimise the obligations placed on them.”

That is what we are worried about: that de minimis obligations will be placed on them, in an attempt effectively to have a free market, a proper market as the Minister said, fully working—I cannot remember precisely the word.

Liz Kendall: Genuine.

Owen Smith: A genuine market. That sounds like a proper market to me. A genuine market working in the NHS. The Minister also took us down an interesting by-way, about how we got to this point. He started to tell us how it was that in response to a question from my hon. Friend the Member for Halton we moved from the original position of the Government—to retain PCTs and simply inject them with more democratic accountability—to this position, where we do not have PCTs and, the surprising bit, where we do not have any further democratic accountability. A particular piece of the jigsaw—democratic accountability for the people commissioning services in the NHS—seemed earlier to be absolutely key. They were PCTs under the old order and there will be GP consortia, NHS trusts or the commissioning board under the new. There is now no democratic accountability for those, so how that piece of the jigsaw got lost in the wash-up between the two parties is very much lost to me.

We know ultimately what we are about here—creating a free market in the NHS. That is what this is about. A lot of the stuff about liberty is a blind because what we have is a fetishistic attachment to price competition and free markets, weaving their magic, as ostensibly they do in other aspects of life, where competition is meant to drive up performance and increase outcomes and productivity. We are now meant to believe that it is going to weave that magic in the NHS. In the Opposition, where we have looked at the evidence and are prepared to talk about it, we are concerned that the evidence shows that when rival providers in health care compete one with the other, one ends up providing bargain basement prices in a way that we have not had hitherto. That may be called evolution, but when we were in
Government we did not have maximum tariffs. We may have had the intention to look at it. Equally, in terms of the selective quoting we have heard quite often, one sees further on in that outcomes framework a suggestion that this would be a big step that would need to be considered very carefully. We did not do it. This Government are doing it; they are introducing a maximum tariff. We have seen and heard clear evidence and concerns from the London School of Economics, expert clinicians and economists, and the chair of the Foundation Trust Network, Sue Slipman. All those people know that the evidence shows that that drives down quality in health care in the US and in Europe, as it would if we were to introduce it in this country. We will end up with bargain-basement health care at bargain-basement prices.

In her evidence, Sue Slipman, when we asked her directly, could not imagine a single area of the NHS, a single service, where price competition could play a valuable role. That was telling. Members of all parties should have listened to that.

Liz Kendall: Does my hon. Friend recall the evidence given by Sir David Nicholson to the Public Accounts Committee and repeated to this Committee? He would not allow price competition, unless he were fully able to measure in detail different elements of quality, and he had

“yet to come across any services that have done that”.—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 7, Q9.]

Owen Smith: What is most remarkable and consistent about all the evidence we have seen—and I think that this has been consistent, too, in statements from some Ministers as the Bill has gestated—is the backtracking away from price competition.

Mr Burns indicated dissent.

Owen Smith: That is what I discern; there is backtracking because increasingly, out there, the view is widely held that competition undermines quality. That point returns to the critical issue of autonomy, which is another area in which we are unclear about the intended or unintended consequences of such significant changes. That is why we think that the Secretary of State should remain not autonomous, or free from such duties, but hard-wired into the NHS and into this place as the ultimate arbiter of decisions taken in the NHS. Without that, we would see a big change.

I turn to the financial justification for the changes, which the Minister has brought up on several occasions. We have heard many times that it is about liberty and unleashing this great torrent of innovation and cleverness into the NHS, but the other point is that it will free up £1.3 billion annually through the reduced costs of commissioning.

Mr Burns: It is £1.7 billion.

Owen Smith: With respect, I think that the Minister said £1.3 billion earlier.

Mr Burns: That was a different figure.

Owen Smith: Fine. Whether it is £1.3 billion or £1.7 billion, why should we believe those figures? They come from a pretty dodgy dossier, which is the economic impact assessment. As well as the chief executive, the chief economist at the Minister’s economic regulator, Monitor, have dismissed many of the economic conclusions within the dossier’s covers. Notably, that includes the important stuff about the analysis the Department of Health has done in respect of market distortions. If the Minister’s economic regulator and chief economist do not believe the figures included within the economic dossier, should we really believe the figures in respect of commissioning? I challenge it, because many other experts in the field have done so and they are not at all sanguine about the volume of savings that the Minister has suggested might be realised. Perhaps he is right, and there will be such savings, but I do not think that that is absolutely certain.

Evidence of successive reorganisations of the NHS shows precisely the opposite. They cost money time and time again. I cannot think of one reorganisation that did not, and I am sure that other Members who have been here for far longer than I have and who have seen far more reorganisations than me cannot list a single major NHS reorganisation that has saved money. The bill for the NHS has gone up and up, and necessarily, we have had to fund it. Obviously, that lesson should be learnt.

I want to turn to Labour’s record, because we have heard a lot about the extent to which the plans are ostensibly an evolution of our proposals. There is some truth there, and we cannot resile from that. We held the door open for the vandals who are now marching through, when we should have been wary and thought through the longer-term consequences of exposing even part of the NHS to market competition and about there being a greater volume of autonomy for the NHS trusts. We did not think through the extent to which our words would be turned, or the extent to which we would see the wholesale de facto privatisation that, in time, I think will come down the track.

Dan Byles (North Warwickshire) (Con): Does that mean that the hon. Gentleman no longer believes in foundation trusts?

Owen Smith: No, I was going to talk about foundation trusts. Crucially, they were set within a far more managed framework. The point that was made earlier, with respect to Alan Milburn, was absolutely accurate. When we had a framework in which there were SHAs, PCTs, and foundation trusts, all sorts of controls were placed on them. As an example of something that the Bill will dump, I will use one provision that was indicative of the different approach we took. In the National Health Service Act 2006, on prudential borrowing, there are conditions about the way in which trusts can borrow money, if they need to borrow more money, or if, indeed they are in financial difficulties. Equally, there are conditions under which the Secretary of State can “give financial assistance”.

How are those aspects dealt with in this Bill? Most provisions about financial borrowing are stripped out, because we are about to liberate the trusts to go out and
borrow money on the markets at the best rates that they can, because we think that that will allow them to be autonomous and to succeed—or potentially, to fail. We have seen, in the current climate, how local authorities have caught a cold when allowed to go out there and borrow or invest on the free market. How we could be contemplating allowing the NHS, with £110 billion, to play the casino with public money is beyond me.

The other aspect is that whereas hitherto the Secretary of State’s job was to give financial assistance and, if necessary, to bail out a failing hospital, under the Bill he is reduced to being a lender. He is reduced to being a bank of last resort, lending at what I presume are commercial rates or better. If he does lend at better than commercial rates we can expect the competition aspects of the Bill to apply to him and the banks will take him to court for undercutting their market with the trusts.

**Liz Kendall:** Does my hon. Friend agree that one of the important changes that advanced by the Bill is that Monitor’s role is being completely swept aside? At present, although it does not always do so as the hon. Member for Stafford would point out, it has the ability to intervene to prevent a foundation trust from failing. It can come in and change the chief executive and other members of the board. The only people responsible for a foundation trust in future will be the governors of the board. It will be entirely within that hospital. There will no outside checks and balances. Does my hon. Friend agree that not having any outside checks and balances is a real risk to all future hospitals?

**Owen Smith:** I wholeheartedly agree, especially when one considers that the Secretary of State is no longer directly responsible. That is the point we are making. All these things are changing. The whole house of cards is being thrown up in the air. Very significant changes are being envisaged and we will not have the same insight or control over the outcomes.

**Grahame M. Morris:** In the event of a failed regime, does my hon. Friend think it will be acceptable to the general public if the Secretary of State washes his hands of a foundation trust—a household name—that fails financially because it is not his responsibility?

**Owen Smith:** No, I do not think that it will be acceptable nor do I think it will be acceptable for the Secretary of State to say, “It’s all right. I can lend you a few bob to bail you out for a bit.” Ultimately I do not think it would be acceptable, as we heard in the evidence and as we touched on in some of the conversations today, if governors of trusts were solely responsible for determining whether they merge one with another. It would be equally unacceptable if there is not greater control by the state in some form over decisions that will have a direct impact on the health care being provided for people in their local communities.

The changes we are considering today in relation to the framework set out in clause 1 are not part of a genuine continuum. They can be presented as part of a continuum, and they can be presented as evolution and that has happened, but it is dissembling. I fear. It is not an accurate portrayal of the way in which the NHS has evolved. Ultimately, we have reached a watershed, a watershed that the Labour party when in office may have broached, but did not breach. We did not step over into a free market in health care. We did not do that for very good reasons. There may be ways in which we can see some degree of greater autonomy for parts of the NHS that will improve productivity and may improve outcomes, but absolutely opening the doors of the NHS to a voracious free market is not what we want to see.

I will conclude shortly, but I want to talk a little more about evidence. We heard a lot from the Minister about the underpinning ethos in the Bill, but very little about the evidence. I hope that as we move through the Bill we will hear a lot more substantive evidence about why we in scrutinising the legislation, and why the public in watching this scrutiny, can have faith that we will not see the NHS—I will not say “fail”, because I think the NHS is too full of good people for it to be allowed to fail—but I will say “falter”. It could falter as a result of these things.

To quote Nye Bevan again—it was cheeky, to say the least, for the Minister to quote the great man from Tredegar—he said, when discussing mixing money and medicine back in the 1940s and referring to the custom of GPs selling their practices to each other, that it ill behoves a civic and civil society for patients to be sold to the highest bidder. I fear that that is where we are going. I also fear that we are going much more quickly towards my other quote from Bevan in 1948 that I gave earlier on, where we will have an NHS that is a patchwork of paternalism and private interest and where tins are shaken in the streets for individual hospitals. We do not want to go down that route. We have gone far too far already. We need to remember what the NHS is about and what the reforms may well destroy.

5.45 pm

**Nick de Bois** (Enfield North) (Con): I am getting used to how the Committee stage works, and the lesson that I have immediately learned is to be brief, which I will try to be.

In summary of clause 1, I want to highlight one key point. We are discussing ending decades of central control of the health service in return for allowing us to accept that it is time to trust the professionals on the front line, who have been working so hard. I suggest to Opposition Members that it may be worth looking at the work today from the other end of the telescope, because we have heard much about problems that must be resolved by the Secretary of State and about everything going back to them. In the past, the Secretary of State was part of the problem, as a result of years of micro-management that has permeated the health service. We have an opportunity, as set out in clause 1, which sets out the framework, to move back to the front line, with professionals in charge and a high degree of localism. Whether that is on issues of reconfiguration or of how money is spent to improve health outcomes in a local area, I welcome it.

From that perspective, if we actually give the front line the opportunity, the local democratic accountability and the ability to plan their own health outcomes, we might see a dramatic reduction in the number of problems that hon. Members constantly refer to as requiring the Secretary of State to solve. It is time to have confidence in the professionals that they can do that.
Emily Thornberry: Will the hon. Gentleman give way?

Nick de Bois: I have a feeling that I know what the hon. Lady may be coming on to, but I will give way.

Emily Thornberry: Given his desire for greater local accountability, will the hon. Gentleman affirm that he has an open mind when it comes to any amendments related to bolstering local accountability in the Bill?

Nick de Bois: I thank the hon. Lady for her intervention, and I will deal with it by saying that, when it comes to local accountability, we must acknowledge that, when compared with what we have been living with for so long, we have made a massive step forward with the proposals in the Bill. I will pick up on an issue that she has referred to. Let me touch on reconfiguration for a moment, because one does not have to take my word for it, although we have experienced it extensively in my constituency, as I know that she has in hers. The deputy executive director at the Centre for Public Scrutiny, when giving evidence to the Committee, was clear that the GP consortia, which would be principally effected by reconfiguration, would have a strong influence on the outcome, because they will be providing the throughput of patients to the potential reconfiguration. He agreed and said:

“Yes, I would expect that to have some influence.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011, c. 34, Q76.]

If, however, they do not welcome it at that local level, it has little chance of going forward. That builds on my point. If we allow local accountability and allow local consortia to have influence at that level, we will have moved forward massively in local accountability. In the past, many problems went to the Secretary of State and all that happened was a rubber-stamping of a process.

Grahame M. Morris: Does the hon. Gentleman accept that there is more than one way to improve local accountability? For example, there is the method that the hon. Member for Southport and others suggested of involving clinical directors at the level to which I have referred. Let me touch on reconfiguration for a moment, because one does not have to take my word for it, although we have experienced it extensively in my constituency, as I know that she has in hers. The deputy executive director at the Centre for Public Scrutiny, when giving evidence to the Committee, was clear that the GP consortia, which would be principally effected by reconfiguration, would have a strong influence on the outcome, because they will be providing the throughput of patients to the potential reconfiguration. He agreed and said:

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Nick de Bois: I am grateful for that intervention. In fact, I warmly welcome it. Let us deal with clinical involvement. I have trouble keeping track, but my PCT has clinical directors, vice-clinical directors and deputy clinical directors, many of whom come from GPs, but despite their best intentions, they have presided over a PCT that has left us in a pretty sorry state in Enfield. More to the point, they have presided over a massive expansion of bureaucracy, so I do not think that tinkering with PCTs is a viable option when it comes to genuine reform of our health service and introducing accountability into a new model, because—this is a key point—the public have lost trust in many PCTs. That is why I echo the words of one of my colleagues, who suggested that Opposition Members are in the unenviable position of defending PCTs.

Emily Thornberry: Will the hon. Gentleman give way?

Nick de Bois: I was about to wind up, but I am happy to give way.

Emily Thornberry: I know that the hon. Gentleman is thinking carefully and clearly about local accountability, and I hear what he says about his hope that local GPs will be closer to their communities and make better decisions on their behalf. Does he not agree that local accountability would be stronger if elected representatives were on GP consortia, or if more elected representatives were on the health and well-being boards?

Nick de Bois: On the health and well-being boards, I do agree. I have a fundamental belief that GPs should be at the head of the consortia, driving them with their knowledge. I do not want that to be portrayed as GPs doing all the form-filling and so forth. I think we are clear about that, but when it comes to the health and well-being boards, I think we have it right. We have a de minimis situation at the moment. Personally, I would welcome it if a health and well-being board wanted to put another councillor on it, if it saw fit to do that. The de minimis situation allows for localism, but it does not allow the Minister to tell the boards what to do, as much as I respect him. That is where I am coming from. After due consideration, I can say that I believe that anything that improves local accountability has to be to the benefit of local people. I have said that since my maiden speech.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): I pay tribute to my hon. Friend the Member for Pontypridd for his excellent speech. Some of the remarks that I wanted to make have been made eloquently by him.

My earlier remarks on clause 1, although made under an inappropriate amendment, none the less relate to an issue that is key to the scrutiny of the Bill: the question of whether it allows the retention of the health service as a universal and comprehensive service for the country. It is clear that there are concerns, in spite of what the Secretary of State said last week and Government assurances given today.

First, the Secretary of State does not have a duty to provide a comprehensive health service in the Bill; the duty to promote such a service and to act with a view to
securing it are substituted for that. Secondly, it is not necessary to secure a comprehensive health service to comply with the Secretary of State’s primary duty. Thirdly, because all duties derive from the Secretary of State, it seems that no organisation will have a duty under the clause to provide a comprehensive health service for the whole country. Finally, as consortia and practices will not have a geographical responsibility, there will be no sub-national geographical unit for making devolved duties to provide a secure and comprehensive health service. That situation will change the present responsibility, which is delegated to primary care trusts. Those issues are crucial to ensure the equitable and universal provision of health services, and are wholly inconsistent with the arrangements in the Bill. We have heard that the Secretary of State will be held to account, but I add a note of caution, because the provision constitutes a major risk.

Grahame M. Morris: I tried to make an earlier contribution without realising that we would come on to a more wide-ranging debate, for which I apologise. I make no apology, however, for repeating some points that have been made. The Bill is very important and I reject some of the suggestions or implications that somehow the coalition has inherited a health service in crisis; it is in robust health. It is well resourced—allocation has increased from £30 billion to, this year, £106 billion—and levels of public satisfaction are at an all-time high. That is not to say that it cannot be improved. I believe, as do many Labour Members, that we could find common ground on the issues of greater clinical involvement and improving accountability.

The Secretary of State will have no role in securing the provision of services. Under clause 1, he will only have to “act with a view to securing the provision of services” when exercising his other limited functions in relation to the NHS commissioning board, the GP-led commissioning consortia and the local authorities. That prompts the question: why do we have a Secretary of State at all, if all those functions are to be handed over to other organisations?

The Secretary of State’s remaining limited functions relate to setting an annual mandate for the NHS commissioning board—do we refer to it as the NCB? Where I come from, that means the National Coal Board. As the Minister mentioned, the Secretary of State makes the standing rules for the board and the GP consortia.

It has always been a fundamental principle of the national health service that at its head is an elected politician—a Secretary of State—who acts as a custodian and ultimately takes responsibility for the provision of high-quality and universal health care. Indeed, as we heard in debate on earlier amendments, the Secretary of State is currently directly responsible for providing, or securing the provision, of all health services, as is set out in the National Health Service Act 2006. I accept the Minister’s comment that many of those functions are currently devolved or delegated to bodies such as the strategic health authorities and primary care trusts, which will be abolished under the Bill. However, that remains the duty of the Secretary of State and, most importantly, he remains accountable to Parliament for the provision of services.

However, under the new arrangements in the clause, the proposed new commissioning structure and the theme running throughout the Bill means that the duty is no longer delegated, but that direct responsibility is taken away from the Secretary of State. Perhaps the Minister can correct me if I have misunderstood, but my understanding is that the Secretary of State would have the duty, as I have described, but because the Committee voted against our amendments, the direct responsibility for securing the provision of health services would be conferred on the NHS commissioning board and the commissioning consortium.

6 pm

It is important that we consider those fundamental changes to the responsibilities of the Secretary of State when considering the new structure of the comprehensive health service under clause 1. I referred earlier—indeed, my hon. Friend the Member for Oldham East and Saddleworth asked the question directly of the Secretary of State—to the repeal of the duty of the Secretary of State to provide the comprehensive health service. His response was that the 1948 duty on the Secretary of State remained the same—indeed, the Minister said earlier today that there will be no change—and that the clause and other provisions in the Bill simply applied it to other organisations as well. I find that difficult to accept. It is important that my hon. Friend’s question about the duty of Secretary of State to provide health services is addressed specifically.

The explanatory notes state that clause 1 “removes the current duty on the Secretary of State in subsection (2) of section 1 to provide or secure the provision of services for the purposes of the health service. Instead, new subsection (2) imposes new duties on the Secretary of State for the purpose of the promotion of the comprehensive health service.”

That is a fundamental and clear difference.

Liz Kendall: Does my hon. Friend agree with my earlier comments that, for many hon. Members, what will matter is which services might be guaranteed in their area or designated under the Bill? We are still very unclear about that process. Monitor has not yet developed the guidelines on such matters so the question that is so fundamental to many of us, which is which services—local A and E services, maternity care and so on—will be designated to us, has not been answered in the Bill. That will not be the Secretary of State’s responsibility, but that of Monitor and we have very little powers in the House in the scrutiny of Monitor.

The Chair: I remind hon. Members that when making interventions or speaking, they must address the Chair.

Liz Kendall: I am so sorry.

The Chair: It is very disrespectful not to address the Chair and it is also difficult for other people to hear. Will hon. Members bear that in mind, please? I did not want to interrupt when the hon. Lady was speaking, but other Chairmen might perhaps not be quite as lenient.

Grahame M. Morris: Thank you, Mr Hancock. I thank my hon. Friend for her intervention, and I sincerely hope that the Minister can respond to some issues if not
in relation to the clause, than during the passage of the Bill. As I have said, the provision is a far-reaching and fundamental deviation from the original text and the founding principles of the national health service.

As the Library briefing note states, part 1 of the Bill sets out a framework from which functions in relation to the health service are conferred directly on organisations responsible for exercising them, with the intention that the Secretary of State retains only those controls necessary to discharge core functions. It would perhaps be sensible to have some clarification on his job description if the Bill is enacted, because I suspect that he will have quite a lot of leisure time. It is perhaps most worrying for us as Members of Parliament and indeed for our constituents that, although the Secretary of State is said to be accountable to Parliament, under the new arrangements he will be accountable only for health service expenditure. There will be no oversight or intervention on behalf of the Secretary of State, and therefore it seems to me—the Minister may be able to address this point—that there is little for which he can be held accountable.

The reforms will be seen by the public as the removal of the “national” from the national health service. Government Members should think about what they would say to their constituents when problems arise. We have already discussed issues around hospital and unit closures and reconfigurations. I am not convinced by the argument that the situation will be better for Ministers not having some direct access and influence in relation to reconfigurations. Indeed, as I am aware from past experience, although the strategic health authorities are much maligned, reconfigurations and mergers most often come about because of clinical imperative. Rarely does some wicked administrator think that it would be a wizard wheeze to close a hospital or bring about a merger. Invariably, the justification is based on advice from clinicians about the safety of the service, ensuring quality outputs and so on. If we lose the SHA s, as is proposed in the Bill, that would be another lever that could no longer be used.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): Does my hon. Friend agree that, under the provisions, there is no point at which a Secretary of State could intervene to prevent further subcontracting, and further reorganisations following further subcontracting? In fact, there is no point at which infinite subcontracting could be prevented, if commercial need dictated it.

Grahame M. Morris: I am grateful for that intervention. It is a very important issue, as is the issue of asset transfer in the event of failure. Again, I hope that we will get some answers and clarification from the Minister at some point, as that is an important aspect of the scrutiny that we are engaged in. It would be completely disingenuous for MPs, when constituents raise such concerns, to do anything other than explain to them what the new arrangements will be. As was said earlier, in many respects, the marketisation of the NHS will mean that the services will be run on a commercial basis, more like a mobile phone provider or one of the big six gas providers. As I said, the new NHS will be independent and market-orientated, and we as politicians will have little or no control over it.

I would like to return to the impact that clause 1 will have on current structures following the establishment of the new bodies under the Bill—the NHS commissioning board and the GP commissioning consortia—and local authorities. I do not want to rehash the arguments about the coalition agreement—

Mr Burns indicated dissent.

Grahame M. Morris: Well, I am not going to do that. I can hear the Minister groaning. [HON. MEMBERS: “Read it out.”] It might be useful for the record if I did. Perhaps Members on the Government Benches are familiar with the wording, but perhaps my colleagues are not. The coalition agreement states:

“We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust (PCT). The remainder of the PCT’s board will be appointed by the relevant local authority or authorities, and the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.”

We seem to have moved a long way from that; the Minister has given us his explanation. Nevertheless, that was the commitment, and many unpopular decisions have been prosecuted—if that is the right word—or implemented in Parliament with the justification of the coalition agreement. In this case, however, the agreement has not been adhered to. During the televised leadership debates that took place in the lead-up to the election, those issues were never exercised or raised. I cannot remember the national health service being mentioned at all.

Only eight months ago, the coalition agreement stated that there would be no “top-down reorganisations of the NHS” to get “in the way of patient care.”

If something walks, talks and quacks like a duck, it probably is a duck. To me, this looks like a top-down reorganisation.

Margot James: I find the constant refrain of “This is a top-down reorganisation and we promised no such thing” a little disingenuous. It is not possible to introduce legislation to reform the health service without that coming from the Secretary of State. Surely the hon. Gentleman should accept that there is a moot point here: although the legislation comes from the Secretary of State, the process enables and facilitates the greatest degree of local autonomy for commissioning and decision making in the NHS, certainly in my lifetime.

Grahame M. Morris: That is an interesting point, but we have to agree to disagree. However the process is defined, it does not seem to have come from within the NHS. Various studies have been presented as evidence by professional bodies, including a large study from the British Medical Association—I refer to that organisation a lot, although I have no particular affiliations with it.

Mr Burns: Well, you have for the duration.
Grahame M. Morris: I accept that. However, there is no strong evidence that this was a bottom-up movement, if that is not a double entendre. [Laughter.] I am sorry—I meant whatever the opposite of a top-down reorganisation is. I will stop digging.

In December last year, the National Centre for Social Research released its most recent survey report on British attitudes. It found that public satisfaction with the NHS was very high. I remind the Committee that in 1997, after 18 years of a Tory Government, 34% of people were satisfied with the NHS. That was the lowest level since the survey began. By 2009, satisfaction had almost doubled to almost two-thirds of people—64%.

Liz Kendall: I shall attempt to intervene in the correct way. It feels slightly strange to intervene on someone whom I cannot see.

The Chair: He hears.

Liz Kendall: Thank you, Mr Hancock. Does my hon. Friend agree that we are lucky, in that in response to a parliamentary question that I tabled, the Department of Health finally published its own MORI surveys of patient satisfaction, which showed that satisfaction with hospitals and GPs was at the highest rate ever? That is testament to the hard work of staff, and to the money and reforms that were introduced.

6.15 pm

Grahame M. Morris: I am grateful to my hon. Friend for placing that on the record. Such sentiments are echoed across the country, even if there are particular issues in particular areas. No one in Labour party pretends that everything is perfect. There are areas that need addressing.

It is far from likely that under the new arrangements there will be a smooth transition to the new structures, due to the sheer magnitude of the shake-up. Once again, there seems to be a problem of public trust about protecting the health service. The hon. Member for Southport raised an alternative, which we debated earlier, and in evidence the Secretary of State responded that PCTs “did not achieve the purposes we were looking for.”—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 159, Q388.]

What purpose could the proposal set out by the hon. Member for Southport not fulfil? Savings could be achieved, because of a 30% reduction in management. Clinical involvement in commissioning, democratic accountability and less risk—because the structure is not fundamentally changed—could be achieved. In my view, many of the objectives could be achieved without such a radical and potentially destabilising restructuring of the service.

We simply cannot quantify the impact that many of the measures will have on patient care and the nature of the NHS. As other hon. Members who have worked in the NHS and the public services have said, and as I know from having worked for 12 years in the health service, having served on an NHS trust board for a number of years and served for many years as an elected member in local government, it is evident that major structural change disables the organisation, at least in the short term. We should be aware of that. Inevitably, the cost estimates of such reorganisations are underestimates, so scrutiny is needed. Chris Ham, the chief executive of the King’s Fund, which is often quoted by the Minister, described the reforms as without doubt “the biggest shake-up of the NHS since its inception.”

I have touched earlier on the costs involved in the abolition of the PCTs and the SHAs. In answer to a parliamentary question, the Minister indicated that those costs would be £582 million, and that figure rises to more than £1 billion when redundancies from arm’s-length bodies are included. A response today indicated that when we take into account the cancellation costs of contracts from PCTs, the figure is in excess of £1 billion. As I remember, it was £1.4 billion, but I stand to be corrected if that is not the case.

The structure that is set out in clause 1, which moves away from PCTs towards privately led commissioning consortia—GP practices are essentially independent of the NHS—goes far beyond the need for clinical involvement. The BMA has outlined its concerns, and although it welcomed further clinical involvement in commissioning, which the Bill contains, in its view the positive aspects of the Bill are threatened by other unnecessary aspects of the reform, particularly the significant move towards private sector competition and competition on price, which this new structure facilitates. The BMA is not alone in saying that major amendments are needed to the Bill in order to prevent destabilisation or potentially a catastrophe in the NHS. As emerged in the course of the debate, the BMA and others are calling for a more “cooperative and coordinated environment where patients are guaranteed the most clinically appropriate and cost-effective care. Price competition and a fully open market will make this impossible.”

I referred earlier to the “Coordinating document for the Impact Assessments and Equality Impact Assessments”. It states that the Government have made it clear that “the reforms amounted to a major delayering, which will cause significant disruption and loss of jobs”.

The Minister is looking perplexed.

Mr Burns: No, I could not hear.

Grahame M. Morris: This is the Department’s own impact assessment and equality impact assessment, which indicates the problems that are likely to arise as a result of the reforms. It states that it is, “a major delayering, which will cause significant disruption and loss of jobs, and incur transitional costs even as the management costs of the NHS are being reduced. The White Paper emphasised that the reforms would have one-off costs”— presumably, redundancy and cancellation of contracts—“and that the Government would ensure that these were affordable within the requirements of the wider Spending Review, while ensuring funding was focused on frontline patient care.”

From past experience, we know that reorganisations tend to cost more than projected and save less than expected, and there is a clear evidence base that the commissioning consortia set out in the clause will need significant managerial and administrative support if they are to succeed.

One of the most interesting pieces of evidence that we have been presented with was the Nuffield Trust report about the US experience. That is relevant, because it states that, “English GP consortia will really struggle unless there is a relentless focus on securing and sustaining high-quality leadership and substantial investment in management”.

I am grateful to the hon. Gentleman for raising an important point. It seems to be underestimating the cost of the reforms, but it is also making the case that it is not only deferring the impact of the reforms, but possibly making it worse. I look forward to the Minister’s response.
The Government’s principal reason for reform—to drastically cut management and administration costs—will endanger the success of its new structure. I mentioned them earlier so I will not go into them, but the numbers that Dr Jennifer Dixon cited in her evidence to the Committee are stark. Some 3,000 groups were established in the early 1990s, of which only 300 are left. She identified two main reasons for their failure was that, “they were unable to take on appropriate financial risk and were therefore torpedoed. They were too small to take on the risk that was given to them. The second thing is that they invested badly in management—they did not see the need for management; they were clinicians who felt a pound spent on management was a pound down the drain. Those are the ones that failed.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 28, Q56.]

The Minister will see that there must be a lesson for our GP consortia and for the moves towards light-touch control.

In support of the structures set out in the clause, the Secretary of State pointed in his evidence to examples in west Cumbria. However, the consortium there has racked up £11 million in debt. The Government say that consortium debt accrued when commissioning consortia take control in 2013 will be the GPs’ liability. That prompts the question of how stable the new NHS structures will be under the new arrangements. The information that I have is that the strategic health authority bailed out that particular consortium to the tune of £2 million this year. Of course, the strategic health authorities will not be in place under the new arrangements.

The hon. Member for Totnes (Dr Wollaston), whom I understand the Government Whips kept off the Committee—it is poorer for her absence—said about the impact on primary care trusts, that “it does look like somebody has tossed a hand grenade at the PCTs”.

More importantly, she has pointed out: “If the expertise isn’t there...inevitably they’re going to be having to turn more to the private sector.”

If Ministers will not listen to the experts on their own Back Benches, we will struggle to make any progress on the Committee.

I was going to talk a little about the public health functions, but they have been well exercised, so I will skip that in view of the time. Make no mistake, the Bill is the biggest shake-up of the NHS since it was founded. As direct responsibility for the provision of health services are handed to the NHS commissioning board, the role of the Secretary of State will be demoted simply to setting the budget.

The new structure set out in the clause not only weakens the position of the Secretary of State to manage the NHS, but reduces the power of Members of Parliament to challenge how our NHS is run. The Minister finished his speech on Second Reading, and his earlier remarks, by saying that he was remaining true to the founding principles of Aneurin Bevan. I will end with a quote from Bevan’s book “In Place of Fear.” He wrote:

“Danger of abuse in the Health Service is always at the point where private commercialism impinges on the Service...Abuse occurs where an attempt is made to marry the incompatible principles of private acquisitiveness with a public service.”

Dr Poulter: I will try to be brief. I hope that I rise on a consensual note, because both sides, this afternoon and this evening, have talked about their wish for greater accountability in the NHS. I am particularly pleased that there is cross-party consensus, given the Tony Blair quotation that the Minister read out earlier, which talked about the need for local accountability. I am delighted that we have support on that issue from a very senior member of the Labour party, who was Prime Minister for 10 years.

We have had a wide-ranging discussion that has not always been pertinent to the clause, but I want to consider accountability briefly. The question we have to ask ourselves as a Committee is whether there is a lack of accountability in the NHS as it stands at the moment. The answer is yes. Where is that accountability? Through the Bill, we are saying that accountability, and the current lack of accountability, are at the local level. Introducing health and well-being boards with democratically elected representatives from councils and tying in the role of councils with clinical leadership from GPs will be a good thing. It will bring much more scrutiny to bear at local level.

We can see that in different areas there are sometimes different health care priorities. For example, in parts of the country where there is an ageing population, there may be a need to address such local priorities. Having that accountability and scrutiny at a much more local level is going to be a very good way of dealing with that. Similarly, there may be areas where there are greater health care inequalities such as higher rates of heart and vascular disease among Asian communities. The Bill will allow local health and well-being boards to scrutinise how local health care policies are being applied locally. That can only be a good thing. The Opposition have failed to give the Government credit for that very genuine and good thing that the Bill will bring about.

Karl Turner (Kingston upon Hull East) (Lab): I shall not keep the Committee long, but it is important to put on record my objection to the Bill in relation to the amendments to clause 1. Without doubt, this is the biggest reorganisation of the health service that anyone has ever seen. That is the evidence that health care professionals offer when asked about the Bill. It is important to contrast that with what was said before and during the general election by the Prime Minister and to consider the words of the coalition agreement that brought the two parties together in this loving relationship.

Before the election, the Prime Minister ruled out any NHS reorganisation, saying: “With the Conservatives, there will be no more tiresome, meddlesome, top-down re-structures that have dominated the last decade of the NHS.”

Just weeks after making that promise, the coalition published its plans for the biggest reorganisation of the NHS in its history, as many Labour Members have pointed out. The coalition agreement supported the idea that the NHS would be protected, stating: “We will stop the top-down reorganisations of the NHS that have got in the way of patient care.”

The coalition has broken many promises over the past months but this must be the most destructive to date.
Clause 1 removes the current duty on the Secretary of State to provide or secure the provision of services for the NHS. Currently, the Secretary of State is directly responsible for providing or securing the provision of all health services, a function which is largely delegated to strategic health authorities and primary care trusts. The clause will fundamentally change the NHS. That raises serious questions about accountability, and many points have been made on that.

The NHS is a huge organisation that needs managing and it must have clear accountability at the top of government. That, I understand, is the evidence of many health service professionals. It is vital that those that control the NHS are accountable to the people through Parliament. A situation where the Secretary of State is not fully accountable would undermine the founding principles of the NHS. The Bill will see 152 primary care trusts scrapped, along with 10 strategic health authorities. The changes are predicted to lead to 24,500 job losses, costing many hundreds of thousands of pounds at a time when it is least expected by a Government who are savagely cutting essential services in the name of deficit reduction.

6.30 pm

Under the Government’s plans, GPs will be handed the bulk of the £100 billion health budget to buy in services for patients and a new NHS commissioning board will oversee the process. That is absolutely revolutionary. It is certainly not evolutionary, as alleged by the Secretary of State. It is an example of the Government going too far too fast. Despite criticism from everywhere—from health-care professionals, patients and the Select Committee on Health—Ministers are determined to privatise the NHS, and are driven by their ideological beliefs in a smaller state.

Mr Burns: Given the hon. Gentleman’s point about so-called privatisation, which I can assure him is totally wrong, will he please tell the critics, whom I think would find it useful, where, in any legislation before this year, has the fundamental principle of the NHS been laid out, stating that it should be universal and free at the point of use for all, and where that is repealed by the Bill?

Karl Turner: I am not sure that I can answer the Minister’s question directly, and I do not suppose that he expected me to be able to do so.

Mr Burns: Yes, I did actually. Will the hon. Gentleman give way?

Karl Turner: No, not at the moment. I am answering the Minister, if he does not mind.

The Bill will open up the health service to a free market. It will allow competition into the health service, which many right hon. and hon. Members, including, I suspect, those on the Government Benches, would disagree with. I hasten to add that that includes the hon. Member for Totnes who, if I am to believe reports in Sunday’s The Observer, was keen to serve on the Bill Committee but was told by Whips that she was not welcome.

Tom Blenkinsop: It is not just the Opposition who say that the reforms are too fast and too soon. I believe that Norman Tebbit also said something similar recently. He was a lieutenant of a former Prime Minister who did much harm to this nation, but even he said that the reforms would go too far. Also, the Bill will lift the cap on private patient care, so the NHS will become free at the point of use to all—with caveats.

The Chair: Order. We have had quite a wide-ranging debate on clause stand part, but I think we have pushed it to the limits of where it can go. I ask Members to bring it back to where we are.

Karl Turner: Perhaps I will conclude on that point, but it is not worth to conclude by saying just that. If £20 billion of efficiency savings are to be made, the NHS needs a period of structural calm, not a major restructure. It needs strong accountability, but the Bill is set to deliver the very opposite. I do not profess to be an expert in the health service, but I speak to doctors, patients who have received health care, constituents and health-care professionals who are lobbying right hon. and hon. Members on both sides of the Committee, and not one of them tell me that the Bill is a good idea.

Mr Burns: I think we can all agree that we have had a fairly comprehensive and interesting debate on the clause, even if some of us have not been in agreement with some of the oft-repeated points made by Opposition Members.

I wish to help the hon. Member for Kingston upon Hull East, who was very good at making a bold, rather fulsome claim about privatisation. It is not the policy of a Conservative party or a coalition Government to privatise the health service. For his education, it is in the 2006 Act that Labour enshrined, under section 1(3), that the NHS will be free at the point of use for all of those entitled to use it. I can assure the hon. Gentleman that nowhere in the current Bill is that repealed, because we do not believe in privatisation. We never have done, and we certainly will not plan to do it. I hope that I have reassured the hon. Gentleman, but I suspect that somehow I have not.

Karl Turner: Certainly not.

Mr Burns: The reason why the hon. Gentleman said that is, despite his comments and the more moderate and honeyed words of the hon. Member for Halton, they have no intention of listening to the arguments, because they have a fixed view or a fixed prejudice and they will pummel away at it from now until the Bill receives Royal Assent. Just to nail the misunderstanding—to put it kindly—let me take the opportunity to emphasise again that the Bill absolutely preserves the founding principles of a comprehensive health service.

Clause 1 retains the overarching responsibility of the Secretary of State to promote the comprehensive health service, a key duty dating from the original 1948 NHS Act, which I am fortunate enough to say was long before I was born. We are committed to a national health service, free at the point of use and based on clinical need and not ability to pay. The Health and Social Care Bill reinforces that commitment. I just hope that there is a little openness in the attitude of Opposition Members, and that they will accept it.
Several members of the Committee, led by the hon. Member for Halton, referred to accountability. I am surprised because, during discussion on the amendments, we went into great detail explaining accountability. In fact, in many ways, the Bill makes the NHS in different areas and factors far more transparent that it is now, and the accountability to Parliament far greater than it is now. I will repeat that, in the hope that, as Opposition Members read our proceedings, it finally sinks in that the Bill is full of increased accountability.

I will start with the mandate that the Secretary of State will issue for the national commissioning board. It will explain the broad outlines and parameters of what we expect the board to do to commission health care for our constituents through the GP consortia, except in those areas where the national commissioning board will do direct commissioning. It will be laid before Parliament and consulted on, and will be updated with consultations. To me, that is great accountability in that area.

Liz Kendall: Will the Minister give way?

Mr Burns: No, not for the moment. I want to make progress because we have had a considerable debate simply on the clause.

For the first time to the best of my knowledge and certainly in recent years, the Secretary of State will be producing an annual report, laid before Parliament. It will have a transparent process where, once it is laid before Parliament, it will be debated and questioned in this House. To me, that great transparency holds responsibility and an account for the Secretary of State. Opposition Members have also spoken about the local accountability of Members of Parliament. I was fascinated by the points made by the hon. Members for Halton and for Easington about reconfigurations. I will get on to that in a minute. I certainly do not want to get bogged down, because I suspect we will be discussing that in far greater detail later in our proceedings.

Members of Parliament, as now, will be able to hold the Government, the Secretary of State and the Department of Health to account through parliamentary questions and parliamentary debates, initiated by Back-Bench MPs as Adjournment debates or by Opposition parties, or even the Government of the day wanting to debate health. Nothing will stop that, and it will also be holding the NHS and the Secretary of State to account through parliamentary procedures. Similarly, I have no doubt that MPs will continue to write to Ministers on general policy or specific issues concerning their constituents, so no change there.

The fears of hon. Members are exaggerated. This is the only way I shall bring in reconfigurations, but opposition Members seem to have a view at the moment, slightly through rose-tinted spectacles that they have immense powers at the moment. We inherited due processes from the previous Government, except that this Secretary of State in May of last year strengthened the criteria for the consultation processes to be conducted so that local people had more engagement. They had have their views taken more into account, because there was a view prior to that that too often consultations were just going through a motion where the public and local clinicians had to be consulted, and then their views were brushed aside because the decision had in fact already been taken.

In the Bill there are ample opportunities for accountability, consultations and for public involvement in them, but with an addition that will now be through the health and well-being boards, and the local government, with whatever form of review it wants, either through overview and scrutiny committees or another form of scrutiny it wants to set up, it will have greater involvement than it does now. Decisions will have to be voted on by the full council, which is not something that happens now, before it goes through other processes. That is far greater involvement and accountability.

Derek Twigg: I apologise if the Minister was coming to my point, but I was conscious of time. We are setting up undemocratic structures in terms of the national commissioning board and the additional powers given to Monitor and the consortia. We are all in favour of consulting, but at what point will the decision be made after all the consultation has taken place? Specifically, if a decision is taken by Monitor or the national commissioning board, and it has caused controversy and MPs are being lobbied by their constituents, the Secretary of State will not have any power to intervene in such decisions.

Mr Burns: The national commissioning board will be involved only as an instigator in reconfigurations for the services that it commissions. As the hon. Gentleman is aware, there will be a consultation process, during which people can feed in their views. There will be a forum for local authorities in areas where the national commissioning board wants to reconfigure a service, and if it affects those local communities, the local authority can also have an input.

Derek Twigg: This is a very important part of the Bill and I do not want to go too far into other parts, but as an example, it is clear from the Bill—the Minister will correct me if my understanding is wrong—that a consortium cannot decide to put out a contract for a service if it does not meet the Monitor’s rules on competition. It is Monitor that will make a decision in certain circumstances—that is what the Bill says. In that case, what I am saying to the Minister is that it appears again in the Bill. Can he confirm that the Secretary of State cannot overrule such a decision?

Mr Burns: If I understand what the hon. Gentleman is saying, there is an element of confusion. I am talking about when there is a reconfiguration of existing services. I think that the hon. Gentleman is mentioning the designation of a service, where it applies in an area, to ensure the continuity of a service. I assume that that is what he is talking about.

Derek Twigg: This goes back to responsibility and accountability. The consortia can put out for a service, yes?

Mr Burns indicated assent.
**Derek Twigg:** That is accepted as a fact. If it does not meet the competition rules, as decided either through the designation or Monitor’s powers, Monitor will effectively overrule the consortia. I am trying to say that there would be no way that the Secretary of State can interfere, if the local people decided that they did not agree with Monitor’s decision, because Monitor has no accountability.

**Mr Burns:** Take a local NHS hospital. It is providing a service in a local area. Any willing provider—that is, another provider—wishes to provide that service as well in the area. What will happen is that, provided that the service reaches the required qualities and standards, that provider will be able to provide it as well, not instead of.

6.46 pm
*Sitting suspended for Divisions in the House.*

7.11 pm
*On resuming—*

**Mr Burns:** I was talking about accountability, on which we had a long debate during our discussion of the amendments. We will return to it later in the Bill, so I will seek to make progress, except to remind hon. Members that Monitor has to produce an annual report, which will be laid before Parliament, so there is accountability there. / Interruption. I am glad that hon. Members are reassured by that.

My hon. Friend the Member for Southport—I will make sure he gets this message—asked whether it would be possible for members of the Committee to receive a note on when the Secretary of State has a role on providers. To always be helpful to the Committee, I will ensure that members on both sides of the Committee receive a note in the not too distant future.

A number of other issues were raised. The hon. Member for Halton is very concerned about the question of data, information and, by implication, statistics. I hope I can give him some reassurance on that because part 9 of the Bill includes the information centre in primary legislation for the first time. We feel it is important not simply for the statistics and information that are provided now, but because, as part of the information revolution, we want to empower patients, too, by providing them with a whole range of comprehensive, accessible and useful information in easily understandable language to help them form opinions on choice. I hope he is reassured by that.

Unless anyone says otherwise, I have dealt with all the valid points raised by hon. Members. I hope in that context that the hon. Members for Pontypridd and for Kingston upon Hull East will forgive me. The latter hon. Gentleman was confused about privatisation, which I have already dealt with. No doubt I have clarified the issue and reassured him that his fears were unfounded.

After what has been a very thorough and interesting debate on clause 1, I invite my hon. Friends, if there is a Division, to agree to clause 1 standing part of the Bill.

**Derek Twigg:** I should say to the Minister that no, he has not answered many of our questions. It will not come as a surprise to him to hear me say that. I say with genuine warmth that perhaps due to the complexities of the Bill, he does not have all the answers to hand, and I understand that. Or perhaps we do not want some things to be heard in the Committee. I suspect that it is the former. When I asked about setting out the duties and powers as a result of the changes, and about specific examples, I was interested that it took the hon. Member for Southport to get a commitment from the Minister to write to the Committee with the information. I will be interested to see what that letter says. We will, no doubt, pursue it further.

**Mr Burns:** To be fair to myself, the hon. Member for Southport was the first member of the Committee to ask for that information. As I said at the beginning, when it is justified, I am more than prepared to help the Committee carry out its duties and functions.

**Derek Twigg:** The whole thrust of the debate has been trying to get more information specifically on the impact of the powers and duties, and on accountability to Parliament and the Secretary of State. We are now in a position in which we will get some more information, although many questions have not been answered. Specifically, it is important that the Minister did not give a real explanation of why he would “act with a view to securing provision of services”.

Why “a view”? Why “a view”?

**Mr Burns** indicated dissent.

**Derek Twigg:** I have been clear that the Minister has not answered the question.

The decision to change the responsibility from being directly responsible for providing or securing the provision of all health services as set out in the 2006 Act is very important. What is happening, and it is clear from what we have heard today, is that powers are passing from an accountable, elected Secretary of State to something we could even call quangos—the commissioning boards, Monitor and, to some extent, consortia. They will have the powers over provision of services, which the Secretary of State had before. That is a massive change in accountability. This is £80 billion of public money being managed in a completely different way by someone who is unaccountable and by institutions that are not democratic.

We have a loss of democratic accountability and powers to Parliament, which we cannot ignore, and it is a very important part of what is happening with the Bill. We have not had answers on those points, which raises concerns. If Government Members think that they will get comfort from consultation changes and other changes at local level somehow stopping the reconfiguration or removal of services, they need to think again. We will cover that at greater length later in the Bill.

**Mr Burns:** I do not want to end this evening on a sour note, and I will not, but I am a tiny bit perplexed by those comments, because I was more than happy to answer those points if the hon. Gentleman wanted me to. Perhaps I misunderstood, but I got the sense that the Committee wanted to make progress today, and because
we will be coming back to most of these subjects, I thought that he was prepared to wait to debate them in great detail.

Derek Twigg: In the spirit of being co-operative and in the friendly atmosphere with which the Committee has so far dealt with the proceedings, we will look forward to those more comprehensive answers as the Bill develops. The fact remains that the Minister has not answered them to date.

Mr Burns: I have answered some.

Derek Twigg: The Minister might think that they were answers, but he did not actually give us the information that we wanted.

The crucial point, which I have been making throughout, is about the Bill’s complexity, and about what the powers in it mean to the health service and, on the ground, to patients. Of course, we will return to those points as we go through the Bill’s various clauses and some in particular will be subject to significant focus by Opposition Members.

We have had several speeches on this clause stand part debate. There was an excellent speech by my hon. Friend the Member for Pontypridd, and the hon. Member for Enfield North gave an interesting and well-thought-out speech. We will return to the sort of comfort he seems to feel from the changes that the Bill proposes, in terms of reconfiguration and other issues.

My hon. Friends the Members for Oldham East and Saddleworth, for Easington, and for Kingston upon Hull East made very good speeches. The hon. Member for Central Suffolk and North Ipswich made an interesting point on accountability, which I will not go over as we will return to that at some point in the future.

The Chair: I thank hon. Members for their co-operation and good humour today. I hope that that bodes well for the next several weeks as we will be in one another’s company for a number of hours twice a week.

Question proposed, That the clause, as amended, stand part of the Bill.

The Committee divided: Ayes 13, Noes 11.

Division No. 6]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Boe, Nick
James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Graham M. (Easington)
Shannon, Jim
Smith, Owen
Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 1, as amended, ordered to stand part of the Bill.

Ordered. That further consideration be now adjourned. —(Stephen Crabb.)

7.22 pm

Adjourned till Thursday 17 February at Nine o’clock.