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Written evidence reported to the House.
Clause 2 under consideration when the Committee adjourned till this day at One o’clock.
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Monday 21 February 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

Thursday 17 February 2011
(Morning)

[MR JIM HOOO in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 43 Moira Gommon
HS 44 Dr Philip Howard
HS 45 Breakthrough Breast Cancer
HS 46 National Federation of Occupational Pensioners
HS 47 Rethink

Clause 2

The Secretary of State’s duty as to improvement in quality of services

9 am

Liz Kendall (Leicester West) (Lab): I beg to move amendment 36, in clause 2, page 2, line 23, leave out ‘with a view to securing’ and insert ‘to secure’.

The Chair: With this it will be convenient to discuss the following: amendment 37, in clause 2, page 2, line 29, leave out ‘with a view to securing’ and insert ‘to secure’.

Amendment 39, in clause 2, page 2, line 38, leave out ‘have regard to’ and insert ‘seek to deliver’.

Liz Kendall: It is a great pleasure to serve under your chairmanship, Mr Hood.

The Chair: Order. I have to tell the hon. Member for Stourbridge that we cannot have coffee in Public Bill Committees.

Liz Kendall: This is my first Public Bill Committee, and the first time that I have moved an amendment. I am sure that we will conduct our debates in a spirit of co-operation, as we did on Tuesday.

First, I shall set out the context of clause 2, as it is important that the Committee should have a proper discussion about quality at the start of our debate. Improving quality in public health services and health care is vital, and that aim is supported by Members on both sides of the Committee and the House.

The investment and reforms of the previous Government helped to make significant drives forward in improving quality in the NHS. The National Institute for Health and Clinical Excellence was established, which helped to develop national quality guidelines in a range of areas of care, from dementia to stroke treatment. National service frameworks were put in place, which helped to make huge improvements—in cancer care, for example. The quality and outcomes framework, a new system of payment, was introduced.

A couple of years ago, Lord Ara Darzi’s “NHS Next Stage Review”, on high-quality care for all, looked to take that agenda forward. Among other things, it led to the establishment of a new National Quality Board, which had strong clinical representation, and a range of other changes have been made that focus services on quality, such as quality accounts in foundation trusts.

Those improvements made a difference. The 2008 Nuffield Trust report “The quest for quality” assessed the results of the changes, and found that “Quality in the NHS in England has improved significantly since 1997. Increased funding and a dynamic reform programme have enhanced both the resources available and the impetus for quality improvement.”

However, far more can and must be done to improve quality; that will always be the case. Members of the Committee are well aware that care in some areas still falls short of what patients and the public rightly expect. That is why the clause is so important.

Earlier this week, the health ombudsman’s report on care for the elderly, which I am sure we have all read, raised significant questions about basic safety and quality care. We know that other areas of care need improvement—for example, care for those with learning disabilities has fallen short—and that there are serious problems in some parts of the system. The vast majority of care is good, but there are still problems, as the hon. Member for Stafford knows only too well. Our ageing population, changing health needs and new technologies mean that the NHS can never stand still. The Government are therefore right to say, as the previous Government did, that quality must be at the heart of the NHS and that it must improve continuously.

Clause 2 introduces the duty of continuously improving quality. According to the explanatory notes, the clause aims to place that duty first on the Secretary of State—on his or her public health functions and in relation to health services. Secondly, the duty will apply to the NHS commissioning board, assuming that it is established following our Committee’s discussions. It will apply also to commissioning consortia, although I am not clear whether it will apply to the providers to foundation trusts. I am sure that we will return to the duty in later debates on the national commissioning board and commissioning consortia. Thirdly, the duty seeks to improve the quality of particular outcomes, but we will go into that in more detail in our debate on amendment 38.

I do not argue that clause 2 alone will secure the delivery of high-quality care for all. Other factors are vital in improving quality. The first is NHS resources, which we all know are extremely tight. Indeed, after the money for social care is transferred to local councils and once real inflation is taken into account, the NHS will face cuts in its resources. It is not protected, as the Government promised it would be at the last election.

The Minister of State, Department of Health (Mr Simon Burns): Yes it is.

The Chair: Order. I will not have Front Benchers interrupting speeches.
Liz Kendall: Thank you, Mr Hood. In fact, the NHS faces its tightest overall funding period since 1950.

Another thing that will help improve quality is capacity—the number of doctors, nurses and other clinicians. We are already hearing from organisations such as the Royal College of Nursing that staff numbers are being cut and posts are being frozen because of funding pressures. The training of health professionals is another vital factor, both pre and post-qualification. I do not want to stray beyond the clause, but I wonder where responsibility for training will lie once strategic health authorities are abolished, because the close association that deaneries have with SHAs has not been taken into account.

We know from evidence, here and abroad, that there are many other levers to improve quality—payment incentives, the regulation of professionals and the system as a whole. However, those changes are not the sum total of what needs to be done to improve quality. Changing the culture between professions and organisations is important. Yes, it is influenced by legislation and structures, but it is also affected by a range of other factors, including the personal relationships between clinicians and patients, and between clinicians and managers. One of the most important findings of the health ombudsman’s report was that the failings in quality that had been identified were both personal and institutional. It is important to bear that in mind.

All those factors play an important role in improving quality, but the Bill seeks to introduce a duty to improve care continuously. That duty must be clear, specific, strong and coherent. Clause 2 falls far short of achieving those goals. The Committee will remember the evidence that we heard from witnesses—it was only last week, but it seems longer than that. They were concerned about how quality will be improved under the Bill and who will be responsible—I shall deal with that in a moment—but they were also most anxious that many aspects of the Bill could harm the quality of care.

Several witnesses said that the changes to be introduced under the Bill would constitute a huge distraction from the real challenge that faces the NHS, which is to continue raising standards of care with increasingly tight resources. My experience of organisational change in the NHS—I was involved in some of those changes in a previous incarnation—is that people take their eyes off the ball. That is true in any walk of life. Anyone who has worked in a business or charity knows that when big reorganisations are under way, people implementing the changes are more on their jobs, or having to reapply for their jobs, than on the outcomes that the organisation wishes to achieve.

Sir David Nicholson, the chief executive of the NHS, has challenged the NHS—the Chair of the Health Committee called it the “Nicholson challenge”—to deliver £20 billion of efficiency savings over the next five years, which represents a 4.5% efficiency gain each year. No health care system in the world has achieved that for one year, let alone for five.

Mr Burns: The hon. Lady is making an interesting point. Would she remind the Committee that what she describes as the “Nicholson challenge” was introduced last year by the Labour Government?

Liz Kendall: Yes, I can easily confirm that, but we did not introduce a huge structural reorganisation that would take people’s eye off the ball. I shall give you an example.

The Chair: Order. The hon. Lady should not be giving me an example.

Liz Kendall: I am so sorry, Mr Hood; I sometimes forget that I am speaking through the Chair. Perhaps I can give you an example.

A colleague who works for one of the London primary care trusts is involved in commissioning important services for dementia care and care for children. She has spent the past six months trying to work out what will happen once the PCT is abolished. She has left the NHS and wonders whether she should reapply for her old job. The NHS will have to make these savings, but the question is whether the Bill will help or hinder the NHS as it does that. I respectfully contend that the Bill will hinder it. That is why members of the Health Committee and many witnesses said that it would be a huge risk to put the NHS through this massive structural change at the same time.

The second broad set of issues raised by witnesses was that it is unclear who will be responsible for driving up standards of care. The Care Quality Commission will be responsible for minimum standards, but not for a continuous improvement in quality. The national commissioning board will be responsible for producing a national outcomes framework and will work with commissioning consortia. The Government’s line of argument is that the commissioning consortia will drive improvements in care.

I draw the Committee’s attention to the fact that witnesses last week expressed real doubts about whether commissioning consortia would have the skills and capacity to drive improvements in care—perhaps not everywhere, but particularly in hospital care. Stephen Thornton of the Health Foundation told the Committee that the foundation’s research showed that in many of the initiatives in which GPs had been given responsibility for commissioning, there had been some effect on community and primary services—but that is to do with things that they already know. There is little evidence that they have had a real benefit in changing in-hospital care. It is important that the Committee should remember that.

The Government also say that patients and the public can help improve quality of care if they have more information and choice. I state clearly for the record that Opposition Members, myself included, have been long-standing champions of giving patients far more information and choice on the services that they receive. Indeed, that principle was enshrined in the NHS constitution, which was introduced by the previous Government. For me, it has always been a point of principle. It is our—by that I mean the public’s—health and our care, and it is our money that pays for it through the NHS. We, as patients and members of the public, must have a say. As an aside, may I say that it is difficult to argue that patients and the public should take more responsibility for their own health and care if they do not have a greater say in that care?
I know from my constituency that many patients want more choice and to get more involved in the NHS. That is central to delivering genuinely patient-centred care. However, as witnesses powerfully told the Committee, patient choice and public involvement should not be seen as a magic bullet or panacea for improving quality.

The Government suggest that patients dissatisfied with the quality of care commissioned by their consortium could simply move elsewhere. It is right for people to have a choice about their GP, but to suggest that people could move to a different consortium that may be many miles away is, to put it politely, to suggest a false choice. It is clear from evidence to the Committee that many patients, particularly those with rare or life-threatening conditions, do not have the time, inclination or capacity to get involved in advising commissioning consortia.

I am sure that many of us were moved by the evidence we received from the patient suffering with ovarian cancer. She said that she will be focusing on staying alive, not on giving advice to GPs. People such as Jennifer Dixon from the Nuffield Trust pointed out that evidence from this country and America—if I am allowed to bring that country into the discussions—suggested that quality of health care is often driven by the culture within services and the nature of the relationship between clinicians, which is often called peer-to-peer review. That does not mean that we should not give patients more information and choice, but that is not a panacea to improving quality.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): The hon. Lady makes her argument well. She is talking about the fact that clinicians commissioning services is important, but apparently that cannot happen because managers make the decisions, not the clinicians. Patients have decisions about their care run through managers. The partnership that she wants to create is between clinicians and GPs, and between GPs and GPs, but at the moment, the structures in place stop that from happening.

Liz Kendall: I thank the hon. Gentleman for that useful intervention. There may well be places where clinicians feel that they are not involved, but from all my experience of the NHS, including my time as director of the Ambulance Service Network, it is not true to say that clinicians do not come together because managers are in the way. I am sure the hon. Gentleman wishes to ensure that all clinicians—hospital doctors, nurses and others—are involved in commissioning, not just GPs. We will come to that point later.

Jeremy Lefroy (Stafford) (Con): Does the hon. Lady remember the evidence from the president of the Royal College of Physicians? His members felt disempowered by the current situation. What does she suggest might improve that?

Liz Kendall: As I said, I think that some clinicians have felt disempowered in the past. I am a champion of greater clinical involvement in commissioning decisions—that point was made clear by the previous Government through Lord Ara Darzi’s review. Rather than throwing all the pieces of the jigsaw up in the air, changes could, or should, have been made to primary care trusts. I am sure we will come back to that issue when we discuss the clauses on the commissioning consortia.

Witnesses spoke about another area concerning quality. I am going through these points because the amendment seeks to strengthen the duty of quality. That is important because the concern is that improvements to quality may not necessarily happen as a result of the Bill. Some witnesses pointed out that the Bill says virtually nothing about improving quality in certain key aspects of care, and the point I am about to make will be important in later discussions. Nine out of 10 patient contacts with the NHS are in primary care.

Maintaining the quality of those services is vital, particularly for patients with long-term chronic conditions, which are the biggest health challenge facing this country. None the less, Dr Jennifer Dixon from the Nuffield Trust said that the “Bill is silent on how else the quality of care may be improved.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 24, Q51.]

If we have a duty to improve quality, it is vital that it should cover all aspects of care.

Finally, the witnesses were clear that some provisions in the Bill will actively harm the quality of care. I am sure that I shall get some interventions on this point. I am aware that I must not stray beyond the scope of the amendments, but it is important to ensure that we listen to the points raised by witnesses about the Bill’s likely effect on quality. [Interruption.] I see that the hon. Member for Preseli Pembrokeshire is raising questions about what I am about to say before I have said it. If this duty seeks continuously to improve quality, it must be strong and clear, particularly if we are worried that other aspects of the Bill may harm quality.

Witnesses said that turning Monitor into an economic regulator with a primary duty to promote competition, introducing EU and UK competition law in relation to the NHS into primary legislation for the first time, and abolishing the structures—PCTs and strategic health authorities—that currently manage the consequences of choice and competition could harm the co-ordination of services, which is so vital to improving the quality of care.

Many witnesses said that there was a real risk that the Bill would lead to a further fragmentation of services. I point here to the “handover” points—I think that an ugly term—between ambulances and hospitals, and hospitals and social care.

The Minister of State, Department of Health (Paul Burstow): May I draw the hon. Lady’s attention to proposed new section 14M of the National Health Service Act 2006, which outlines the duty in relation to quality of primary medical services? The hon. Lady suggested that there is no duty on consortia to deal with issues of quality, so I just wanted to ensure that she had not missed that particular clause.

Liz Kendall: With the greatest respect to the Minister, I did not suggest that there was no duty on GP commissioning consortia. I said that Dr Jennifer Dixon,
an eminent researcher, said that there is virtually nothing in the Bill about how—[Interjection.] Will the Minister listen?

If primary care is commissioned by a national board, how will it know exactly how to improve the quality of care? I know that the Minister may say—[Interjection.] It was not a partial quote. I am sure that Members can see it in last Tuesday afternoon’s evidence session. Dr Jennifer Dixon said that it was unclear how the Bill would continuously improve the quality of primary care. There may be a duty, but simply asserting something in the NHS does not, alas, make it happen.

**Dr Poulter:** In that case, can the hon. Lady explain why she has tabled the amendments? The words in the clause are perfectly reasonable, but she wants to tweak and change them. Then she says that asserting things does not make them happen in practice.

**Liz Kendall:** I refer the hon. Gentleman to the evidence that Sir David gave to the Public Accounts Committee. He said that we cannot have price competition without defining the quality of services, yet no service has been able to provide such a definition. That is why the clause needs to be strengthened.

**Dan Byles** (North Warwickshire) (Con): I am sure that the hon. Lady was greatly reassured when Sir David Nicholson said:

“I do not accept the premise that the economic regulator is there to do price competition... We are... about competition on quality, not on price.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 9, Q18.]

**Liz Kendall:** I refer the hon. Gentleman to the evidence that Sir David gave to the Public Accounts Committee. He said that we cannot have price competition without defining the quality of services, yet no service has been able to provide such a definition. That is why the clause needs to be strengthened.

**Dan Byles:** What Sir David said to that Committee does not contradict what he said in evidence to us. He did not say what price competition could do; he did not accept the premise that the economic regulator had anything to do with price competition.

**Liz Kendall:** I respectfully accept that Sir David has many years’ experience, but the evidence that we received from a range of witnesses shows that the Bill will allow a maximum price under which people can compete to deliver care. We shall deal with that aspect later.

**Owen Smith** (Pontypridd) (Lab): Was my hon. Friend as surprised as I was to hear the chief executive designate of the national commissioning board say that price competition was going to be a big factor? Indeed, other Ministers were rowing back from that premise. Given that the Bill allows a maximum tariff—

**The Chair:** Order. The hon. Gentleman is tempting other hon. Members away from the amendment. I ask those who wish to intervene to be brief and to speak to the amendment.

**Liz Kendall:** Thank you, Mr. Hood. I am sure that we shall return to those matters later in the Bill.

There are real concerns about the impact that the Bill will have on quality. It is vital that the Secretary of State's duty to improve continuously the quality of health and health services, set out in clause 2, should be clear, coherent and strong. Amendments 36, 37 and 39 seek to strengthen that duty.

Clause 2 states that the Secretary of State must exercise his functions

“in relation to the health service with a view to securing continuous improvement in the quality of services”.

It also states that in discharging this duty, the Secretary of State must

“act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.”

Amendments 36 and 37 would make that provision clearer and stronger, as the clause would state that it was the Secretary of State’s duty “to secure” those improvements—not merely “act with a view to” or “have regard to”. Some people are concerned that the Bill could harm quality, so it is important to make the duties and responsibilities of the Secretary of State clear.

Amendment 39 deals with the Secretary of State’s responsibilities in relation to the quality standards prepared by NICE. Over the years, NICE has done some excellent work in setting out the best evidence on various kinds of care. Indeed, it is a world leader in that respect, and many health services turn to NICE’s quality standards.

What makes those standards increasingly excellent is that NICE does not focus only on drugs or health care interventions, but on prevention, involving patients and the public in making care genuinely patient centred, and defining the very best national standards in quality of care. That is vital for whoever commissions care; currently, it is the PCTs, but the Government are seeking to make it the commissioning consortia. However, the Committee will be aware that some PCTs do not always implement the NICE guidelines.

We heard from NICE’s chief executive, Andrew Dillon, on that point. He agreed that there are likely to be precisely the same problems if commissioning consortia are to implement the NICE guidelines as there are now with the PCTs. In fact, it could be more difficult for consortia to implement them.

**Dr Poulter rose—**

**Liz Kendall:** I shall give way to the hon. Gentleman in a moment. If the consortia are responsible for a smaller number of people than primary care trusts, as in some parts of the country the pathfinder projects already are, just a couple of patients with very expensive health care needs could put them into debt.

We know that the Government are aware of the problem, because Jennifer Dixon revealed to the Committee that she had been commissioned by the Department to
[Liz Kendall]
do some economic modelling to show the optimum number of patients for a consortium—the population coverage that would reduce the risk of being put into debt by one or two expensive patients. I respectfully ask the Minister whether he would be prepared to publish that modelling and evidence if it is ready during the passage of the Bill.

9.30 am
My point is that the key challenge for the NHS, as for any other health care system in the world, is how to get the best value and best care in the context of growing—if not infinite—demand, within finite resources. That is the key decision. The Bill simply shifts that challenge from primary care trusts to GP consortia, which may be less well able to deal with it because they cover a smaller population.

If we believe that the NICE guidelines are some of the best standards in the world, and we want them to be implemented—and Opposition Members do, as I am sure the Minister does, or he would not support them—it is right for the Secretary of State to have a clear responsibility to ensure that they are implemented, as amendment 39 would provide. Instead, therefore, of requiring the Secretary of State to “have regard to” the standards, under the amendment the clause would give him a duty to “seek to deliver” them.

We need to strengthen the Secretary of State’s duty to improve quality continuously for the reasons I have given. Quality is important and Members on both sides of the Committee support it. We need to be aware of people’s concerns that the Bill could negatively affect quality and that it is unclear who is responsible for it or how it would be secured. The amendment would resolve that.

Grahame M. Morris (Easington) (Lab): I want to speak fairly briefly, as I am sure hon. Members will be. Members will be relieved to hear, because I do not think that amendments 36, 37 and 39 are controversial; in fact, they strengthen the hand of the Secretary of State in relation to his duties.

As my hon. Friend the Member for Leicester West has said, clause 2 focuses on the Secretary of State’s duty to ensure that there are improvements in the quality of health services that are provided as part of the national health service. On Tuesday, I and other right hon. and hon. Members spoke about the inadequacy—at least in the Opposition’s view—of the new, slimmed-down role for the Secretary of State, in so far as his powers are to be conferred on subordinate bodies. The Opposition raised concerns that the Bill would diminish the Secretary of State’s accountability to Parliament.

Amendments 36, 37 and 39 would put more emphasis on the duty of the Secretary of State and would strengthen his role in improving patient care. Amendments 36 and 37 would simply alter the phrasing of the Bill to make the Secretary of State’s duty with respect to quality improvements unequivocal. Under the clause, the Secretary of State would have to exercise his functions in relation to the health service “with a view to securing continuous improvement in the quality of services”.

The amendments would change the emphasis because they would instruct the Secretary of State to secure the improvements. The change would apply to improvements in the quality of services and the outcomes achieved by their provision.

We know from evidence and statements by the Secretary of State and the ministerial team that they are great believers in the primacy of outcomes over targets. The Secretary of State told the Committee that the reforms are part of his quest to improve quality and outcomes for patients. In those circumstances, what reason can the Minister have for opposing the amendments?

Jeremy Lefroy: I have a lot of sympathy with what the hon. Gentleman says, but let us suppose that he or I became Secretary of State for Health—no doubt I never will—and had the duty to secure continuous improvement in the quality of services. I am sure that he agrees that we live in the real world. If the Secretary of State had such a duty, it would be impossible for them to carry out that duty, however great their ability. They would be subject to legal challenge at almost every juncture. As a layman, that is my point.

Grahame M. Morris: I am grateful to the hon. Gentleman for the intervention, but I honestly think that there are possibilities of legal challenge all through the Bill. I suspect that the legal profession are rubbing their hands at the thought of the additional work that they will secure as a consequence of the Bill. In response to his specific point, it is important that Ministers of the Crown have specific duties and targets by which their performance can be measured. Otherwise, how do we know whether they are successful? There is value in setting a specific duty on the Secretary of State.

The functions that the Secretary of State is to exercise under the clause are too vague and might simply refer to his dealings with the NHS commissioning board and GP commissioning consortia. Placing a stronger duty on him to improve services and outcomes would be a small but meaningful intervention and give him an impetus to take action, intervene and give instructions to the board and consortia. Accepting the amendment would make such a proactive approach more likely.

I accept that there many other factors contribute and are, indeed, imperative to improving quality and outcomes. In fact, many instruments that Labour used to secure service improvements have been stripped away by the coalition Government. We have already discussed the role of the strategic health authorities under clause 1. That opportunity and lever will no longer be available, so it is more important to strengthen the powers of the Secretary of State.

The Secretary of State and Ministers have assured us on many occasions that price competition will not be the driving force behind health provision. When my hon. Friend the Member for Pontypridd asked the Secretary of State, in the fourth evidence session, whether competition was “going to be principally on price, cost or quality”, the Secretary of State replied unequivocally: “on quality”.—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 161, Q391.]

We are told that the whole system of health care set up by the Bill is focused on improving quality. If that is the case, why would it not place a stronger duty on the Secretary of State to improve quality?
Amendment 39 would strengthen the duty on the Secretary of State by requiring him to “take account of” rather than simply “have regard to the quality standards prepared by NICE under section 218”.

Again, we are simply asking whether the Secretary of State should have a strengthened role in securing the improved quality and outcomes that he assures us are the intention behind the Bill. If NICE is to be directed to prepare statements of quality standards in the provision of NHS services, public health services and social care in England, we should expect that to influence the functions of the Secretary of State. As many witnesses have testified, the reorganisation set out in the Bill creates the risk of a loss of focus on outcomes. That could be the biggest danger to improving the quality of outcomes in the NHS.

The improvements achieved by Labour in reducing waiting lists—undoubtedly a considerable improvement, much valued by patients—increasing expenditure on the service, improving services and doubling the rate of public satisfaction, could be put at risk by the provisions. The changes in the Bill could be a huge distraction from quality and outcomes. The amendment would place a greater obligation on the Secretary of State to ensure that quality improves, despite the dangers posed by the reorganisation. I urge all hon. Members to support it.

John Pugh (Southport) (LD): We are in danger of having a Second or Third Reading debate on every amendment. If we do that, we will be here until Christmas—some hon. Members might regard that with less equanimity than others—and we certainly will have failed to scrutinise the detail of the legislation.

I will concentrate on the amendments’ wording and speak only about that. Amendments 36 and 37 would remove the words “with a view to securing continuous improvement”.

and replace them with “a duty to secure continuous improvement”.

That is not a change in emphasis; it is the substitution of a possible duty by an impossible duty. As the hon. Member for Stafford pointed out, there is no way that the Secretary of State can be guaranteed to perform the task that Parliament would be mandating him to do. There may be circumstances, for example, where a service is as good as it can be. Must the Secretary of State carry on seeking continuous improvement in a service that is perfectly satisfactory and satisfies all those who use it? Continuous change can be secured by the Secretary of State. Some people argue that that is what Secretaries of State have done and continue to do to this day, but continuous improvement is like someone being asked to improve their behaviour continuously: it is worth trying, but not something that they could guarantee to achieve.

I am not sufficiently malicious to wish to visit an impossible duty on the Secretary of State. Although I accept that the Secretary of State is powerful and can genuinely act with a view to securing continuous improvement, I assume that he is modest enough to think that that will not always be possible for him to secure continuous improvement. That is why the wording in the Bill must stand. Otherwise, we will be asking the Secretary of State to do something that is infinitely beyond his capacity.

Owen Smith: To pick up where the hon. Member for Southport left off, the Opposition and Government Members fundamentally disagree on the extent to which the clause effects a change in the nature of the duties placed on the Secretary of State. In the amendment, we seek to clarify the point that all health Acts in the past 60 years, starting with the first in 1946, have placed a clear duty on the Secretary of State.

In the National Health Service Act 1946, the then Minister of Health was under a duty to “promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales.”

That provision was brought up to date by the National Health Service Act 2006, which states:

“The Secretary of State must continue the promotion in England of a comprehensive health service”

and must “provide or secure the provision of services in accordance with this Act.”

Our simple point is that there is a difference between the Secretary of State acting “with a view to” securing and providing. The latter placing the matter at arm’s length and has the Secretary of State operating through what is effectively, as we said the other day, a quango.

Dan Byles: We are in danger of tying ourselves in semantic knots. The hon. Gentleman says that the Secretary of State must promote the health service, but that sounds far more like the wording of the Bill than that of the amendment.

9.45 am

Owen Smith: With all due respect, it does not. All the Bills referred to promotion; the significant difference between this Bill and all the previous ones is that this one talks about the Secretary of State acting with a view to or acting with regard to securing or providing, whereas all previous iterations initially placed the duty upon him to promote, and thereafter talked about him securing or providing, which is a far more direct duty than the arm’s-length, distant, free and liberating one implied by “acting with a view to”. Our simple question is: what exactly do acting “with a view to” or acting “with regard to” mean, and what happens in the event that the Secretary of State fails to do that?

Jeremy Lefroy: Does the hon. Gentleman accept that there is a duty in the Bill to secure continuous improvement, which was not in the 2006 and 1946 Acts? That word, “continuous”, is vital.

Owen Smith: I absolutely accept that, and that word would be a really useful addition to the Bill were it far more clearly explained and articulated therein. I was going to come on to the inclusion of that important word in the clause. I agree entirely that it would be a valuable addition, if we could measure continuous year-on-year improvement—as is implied—right through the NHS. However, given that we have heard in discussions elsewhere that we will not have targets to the same extent as hitherto, and given that the Minister has told us that we will have only clinical targets—valuable clinical targets—it is difficult to see how, in an NHS as
diverse as ours, with economic and non-clinical measurements that need to be taken into account, we can ever be certain that improvement is continuous.

The clause refers to acting with regard to securing that continuous improvement in respect of treatment, which surely implies that we will need some measurement of the volume of people being treated and the extent to which they are being treated. Such things are rather less clinical than the sorts of outcome measure that we repeatedly hear the Secretary of State and Ministers refer to as the only valuable and valid targets that might be applied under the new NHS regime. There is a contradiction between the duty to provide continuous improvement and the ability to measure it. I understand that there will be a mandate for the NHS in its various new functions to produce a document only once a year.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): On that mandate and the document published once a year, if questions were asked in Parliament about the ongoing process, the Secretary of State could be referring to that document 365 days after its publication—

The Chair: Order. The hon. Member is going a bit wide of the amendment.

Owen Smith: If I may, Mr Hood, I do think that my hon. Friend makes an interesting point—

The Chair: Order. However interesting the point is, please speak to the amendment.

Owen Smith: My second question is that if clear targets are not enunciated in either the mandate, by the Secretary of State, or the Bill, how will patients in this new and rather more disaggregated NHS have the ability to discern whether their bit of the NHS is continually improving, or how it is performing in comparison with other parts? If the continuous improvement is a new and, as has been suggested, a valuable addition, surely we need to be able to measure it far more carefully.

Dr Poulter: Is the hon. Gentleman seriously suggesting that hospitals and GPs will cease to do audits to monitor how their services are working on the ground?

Owen Smith: No. I am sure that all those things will continue to happen. My point is that the Secretary of State will be under a duty to act with regard to securing continuous improvement but, as patients, we will not be able to discern whether that is actually occurring, without some sort of aggregated target or set of targets allowing us to determine the truth of that. Otherwise, how will we know that there is this continuous improvement?

Dr Poulter: NICE will set up a national framework for clinical practice, against which local audits will be carried out. Does the hon. Gentleman agree that that is a good way of assessing whether local services are being delivered according to the national guidelines and targets?

Owen Smith: Again, I entirely agree. That is perfectly legitimate and it is how the NHS has worked hitherto. My point is that the duty to secure continuous improvement is new, but the current audit system effectively provides us with a spot check on that particular service at that juncture, and the extent of its performance against the targets set down. We will not be given a sense of whether that continuous improvement is occurring.

Dan Byles: The hon. Gentleman seems to be suggesting that, without the amendment, patients will not be able to tell whether the NHS is improving. I find that a remarkable suggestion. As my hon. Friend the Member for Central Suffolk and North Ipswich said, there are numerous measures and methods by which the NHS can be measured to see whether it is improving, and a semantic change in the Bill as proposed in the amendment makes no difference to any of them.

Owen Smith: I am not suggesting that patients will not be able to discern whether the NHS is improving. We can clearly see from the evidence that patient satisfaction ratings are at an all-time high, as a result of the increased investment that the Labour party put in. However, I am suggesting that the new duty and the new suggestion—political, I think—that there will be continuous improvement, which is somehow different from the improvement we have seen hitherto, will not be able to be substantiated under the terms and targets set in the Bill. Unless we also have a return to the type of targets that we used effectively, such as the 18-week waiting time, we will not be able to measure properly whether the duty is being achieved.

Finally, other aspects of the Bill militate against quality and certainly against continuous improvement in quality. Some of those we have heard enunciated, with clear evidence right across the board that price competition does not sit easily with continuous improvement in quality, but sits quite easily with continuous decline in quality.

Dan Byles: I found it remarkable that when Professor Le Grand gave his evidence, although he agreed with the hon. Gentleman that price competition had the potential to drive down quality, he made an interesting point:

"Although that provision in the Bill has been carried over from the previous Government’s operating framework."—[Official Report, Health and Social Care Public Bill Committee, 9 February 2011; c. 20, Q44.]

Owen Smith: We have heard that point made several times, including my response to it, which has been very clear. We might have broached that particular change, we did not breach it. It was considered but, if one reads on, the outcomes framework also said that it would be a real step change for the NHS to go down that route. When my party was in office, we did not go down that route. New in the Bill—for the first time—is that there will be a maximum tariff, and therefore the ability to compete below that tariff, driving down quality. That is the clear lesson.

Margot James (Stourbridge) (Con): Why does the hon. Gentleman assume a direct link between a reduced price and reduced quality? That is often not the case. In my primary care area of Dudley, I have seen numerous
examples of improvements brought about by GPs in the service at a reduced cost. Similarly, in our ambulance service, the combined operations centres have reduced cost and improved quality. Can he not accept that sometimes there can be a price reduction and an improvement in quality? That will enable the ultimate improvement in quality, which is that a greater number of patients are able to receive as good a quality of care as if they were to be maintained at an artificially higher price.

The Chair: Order. The intervention should be shorter. I did not want to interrupt the hon. Lady but in future interventions should be shorter.

Owen Smith: I am grateful to the hon. Lady for her intervention, because it betrays the overwhelming philosophical bent among Conservative Members that introducing market forces—price competition being one of the ultimate market forces—may improve quality, as it does in telecoms, utilities or in other things that are not health care. The overwhelming academic evidence from America, where Medicare and Medicaid do not have price competition for that precise reason, and from Europe was given to the Committee in the evidence sessions last week. The head of the trusts, Sue Slippman, Monitor and the chief executive of the NHS could not imagine any services in which we should introduce price competition. The overwhelming evidence is that it drives quality down, not up.

The other thing that will militate against delivering continuous improvement in quality in the NHS is the effective break-up of the NHS caused by the Bill. The NHS will be a more disaggregated service with more private providers and more subcontracting.

Several hon. Members rose—

The Chair: Order, at the very least we are moving towards a stand part debate, and, as the hon. Gentleman suggests, we are perhaps going down the road of reviewing the Bill's Second Reading. Please speak specifically to the amendment.

Owen Smith: I hear your words, Mr Hood, and I shall sit down in a moment. I was simply highlighting several aspects of the Bill that are relevant to the clause because they relate to quality.

Mr Burns: The amendment.

Owen Smith: Okay, the amendment. I shall leave it there.

Karl Turner (Kingston upon Hull East) (Lab): It is always a pleasure to serve under your chairmanship, Mr Hood.

I want to make one or two points, which I suspect have already been made by fellow Opposition Members, but I think it is important to get my concerns on the record. The clause creates a duty on the Secretary of State to act only with a view to securing continuous improvement, rather than merely having a view to doing so.

The amendment would go much further than has been suggested by Government Members. It is not merely a semantic argument; it would provide assistance to the Government and secure the legislation.

John Pugh: We might as well get this straight. Does the hon. Gentleman really believe it is possible to secure continuous improvement across the range of NHS services ad infinitum? If so there is a disagreement between the Government and the Opposition. Could he make it clear whether he is actually saying that? I want him to say that he believes it is perfectly possible to secure continuous improvement ad infinitum.

Karl Turner: I am, yes. I am happy to have on record my belief that it is possible. The Committee has received evidence to that effect. [Interruption.]

The Chair: Order, hon. Members should not get excited.

Tom Blenkinsop: The amendments address the lack of individual and collective aspiration in the clause for what the Secretary of State is there to achieve. The national health service was founded on the principle that we would try to improve health outcomes for all people in this country ad infinitum.

Karl Turner: My hon. Friend's helpful intervention assists both the Committee and me.

Dan Byles: I agree that the hon. Member for Middlesbrough South and East Cleveland made a helpful intervention. Change the word “try” to “seek” and he is entirely supporting the current turn of phrase. He should be voting with us.

Karl Turner: The clause also requires the Secretary of State to act with a view to securing continuous improvement in outcomes achieved from the provision of services. The amendment clearly offers assistance to the Government and would improve the Bill. Amendment 37 would make the Bill more robust and ensure that the Secretary of State has a duty to secure improvements in outcomes for patients. New section 1A(4) of the 2006 Act places a duty on the Secretary of State to “have regard to the quality standards prepared by NICE”.

Again, the amendment helpfully assists the legislation.

10 am

Amendment 39 would ensure that the Secretary of State sought to deliver the standards prepared by NICE. Again, in my respectful submission, this amendment strengthens the Bill and ensures that the standards prepared by NICE are actively delivered, rather than the guidelines simply being referred to.

Clause 2 is about quality of services, and it signals a move away from targets towards an outcome-based approach. I am concerned that the Bill is not clear...
enough about what quality means. I hope that the Minister can explain his definition of quality.

I am also concerned that there is a focus on outcomes in the Bill. Again, there is no definition of outcomes in the body of the Bill. I understand that my concerns are supported by the Royal College of Surgeons, which says that the minimum standards of care are not set out in the new arrangements to introduce greater competition. Quality of services must be clearly defined if we are to avoid a race to the bottom when price competition is introduced.

Once the Minister has clearly defined what he means by quality and outcomes, the Secretary of State must be obliged to secure continuous improvement in both areas. The quality of care that our constituents expect is too important to be left in the care of an ambiguous definition in overly flexible legislation. In the written evidence submitted to the Committee, NICE welcomes its increased role. The fact that it specifically mentions the need for Government direction underlines my concerns that the clause, as it stands, is far too weak.

I agreed with NICE when it said that “it is important that the health and social care system receives a clear signal, from Government, about how it expects it to respond to NICE standards and our other advice.”

Tom Blenkinsop: Is it not the case that without these three amendments, the clause belies the confidence of Government Members in their own Secretary of State?

Karl Turner: I am bound to say that I agree with my hon. Friend. In fact, I could not have put it better.

The Government have laid out that they will respond to NICE standards, but they have neglected to explain how they will respond. I cannot see anyone objecting to the Secretary of State’s being mandated to defend the quality of services within the NHS given that he is exposing the health and well-being of the general public to the whims of an unfettered market. I do not intend to say more on that point, Mr Hood, because I know that you would call me to order. For the reasons that I have outlined, I support the amendments and I urge the Committee to do the same.

Mr Burns: Mr Hood, may I add to the comments of the hon. Member for Leicester West in welcoming you to the Chair? May I also pay tribute to the hon. Lady for what is her maiden contribution in a Committee hearing? Fluent it was. The content was not quite so good from the point of view of the Government, but there is scope for improvement and development in the coming weeks. [Interruption.]

The Chair: Order. Hon. Members should not interrupt the Minister when he is complimenting someone.

Mr Burns: Amendments 36, 37 and 39 seek to revise the duty of quality, placing the Secretary of State under a direct duty to improve the quality of services. I think that we come to the aim behind the amendments with a common purpose. Nobody in this Committee wants the national health service to provide anything but the highest quality of care. It comes as a considerable relief to me that we are united in starting from the premise of improving quality, although we begin to part company over how to achieve that with regard to the role of the Secretary of State.

As the hon. Member for Southport said in his eloquent contribution, the Secretary of State cannot be held personally, directly responsible for quality levels. Furthermore, if the level of quality is already at its highest, pushing it higher would be an impossibility.

Grahame M. Morris: Will the Minister give way?

Mr Burns: No, I am sorry. I am going to make progress.

Grahame M. Morris: It is very important.

Mr Burns: Every intervention from the hon. Gentleman is important.

Some of the ideas suggested by Opposition Members seem superficially attractive as a good way of getting things done, but their approach would undermine the devolved responsibility that the Bill seeks to establish and bring responsibility for provision of NHS services back to Whitehall, by giving the Secretary of State a direct duty to deliver improvements in the quality of the service.

The Government have said on the record and constantly repeat that we acknowledge the good ongoing work being carried out to improve and drive up standards. We recognise the importance of the work of the noble Lord Darzi in putting stronger emphasis on quality; it would be churlish not to. At least we have the confidence and maturity to accept when something is being done well or has gone well and to seek to build and improve on it further. That might be a lesson that others could learn.

Mr Kevin Barron (Rother Valley) (Lab): Lord Darzi’s review considered quality. The national health service did a pilot scheme in the north-west called “Advancing Quality”. It was a four-year scheme and started, I think, in 2007. What evidence came from it to show that we can improve quality by using incentives in our national health system?

Mr Burns: I am grateful to the right hon. Gentleman for that intervention. I will deal with the question of how we can incentivise, encourage and deliver improved quality. If he will bear with me, I will develop that theme, but first I will return to clarifying the role of the Secretary of State.

No one person, organisation or part of the NHS’s functions will be the engine and driving force for improving quality. That will be the combined function and job of everyone—all organisations and all proposals and plans within the NHS. However, it is clear that the Secretary of State will unambiguously set out quality expectations in the outcomes framework and the annual mandate to the national commissioning board. The duty of quality will run throughout the whole system. The NHS commissioning board and commissioning consortia will be under a duty to have regard to the need to improve quality. Members of the Committee who have read the Bill will know that.
The NHS will have the freedom to achieve improvements in quality in ways that make clinical sense locally. Clinicians, not bureaucrats, will decide how best to improve outcomes for patients. Quality will be a key reporting theme in my right hon. Friend the Secretary of State’s annual report on the performance of the NHS, which is one of the key ways in which he will be accountable to Parliament. That is all quite clear.

I want to respond to the hon. Member for Kingston upon Hull East, who asked about the definition with regard to outcomes. If he had read the legislation that we are debating today, he would see it quite clearly on page 30 of the Bill. That, hopefully, answers his points.

Owen Smith rose—

Mr Burns: I will not give way; I am going to deal with questions raised in the debate. The hon. Member for Leicester West raised several, including who was responsible for driving up quality. As I have said, but I will repeat it to her, not one body or person but all parts of the system have a responsibility and will exercise it. It will happen primarily through better commissioning, based on NICE quality standards, and clinicians will have an important and critical role in improving quality. The Bill lets them do that.

The hon. Lady asked whether the duty of quality will apply to providers. I can tell her that providers will be held to account for quality of service through contract commissioners, provider quality accounts, health and well-being boards, HealthWatch and CQC maintaining essential standards. I hope that that deals with her point.

The hon. Lady also asked where responsibility for deaneries will sit within the new system. As the hon. Lady is aware, we are consulting on the future of professional education, because I agree with her that it is absolutely crucial that we have the highest quality education and training to ensure that not only do existing staff within the NHS maintain their professional standards, but that we have the next generation and beyond being trained for a high-class NHS. We are consulting and we will consider the responses before making a decision, which will be taken in the best interests of patients and staff.

We had a fairly long and protracted debate about the question of acting “with a view to” and the meaning of “have regard to”. The duty to act with a view to securing continuous quality improvement in quality is not weak, nor is it unclear. The Secretary of State would have a statutory duty under the legislation to exercise all his functions in a way that is best calculated to achieve quality. The Secretary of State could be challenged in court by anyone who thought that he was not doing what he could to achieve the objective of improving quality.

On the meaning of “have regard to”, I warn the Committee that I am not a lawyer. Those who are lawyers will understand the full significance and meaning of what I am about to read. A former Lord Chancellor, my noble Friend Lord Mackay of Clashfern, spoke about the term when it was being debated in the context of the NHS constitution. He said:

“This is a very common phrase...and I have been involved in arguing cases and sometimes deciding cases in which it was a crucial phrase. I will not be giving a definitive meaning for it, but I think what, in principle, it means, is that, in making a decision, you take account fully of all the provisions of the document so far as relevant to the issue in hand and you take account of them properly and seriously, not in a dismissive way...It is a compendious phrase with very considerable legal lineage in which it is applied. I do not think there are many cases in which the judges have attempted to say what it means; they know how to apply it.”—[Official Report, House of Lords, 28 April 2009; Vol. 710, c.159-60.]

Emily Thornberry (Islington South and Finsbury) (Lab) rose—

Mr Burns: A lawyer is about to intervene on me. I warn the hon. Member for Islington South and Finsbury that if she is going to ask me a question on a point of law, I may, sadly, have to side-step it.

10.15 am

Emily Thornberry: I reassure the right hon. Gentleman that I would not be tempted to do that. However, speaking as a lawyer, I ask him why he is giving extra work to lawyers. Why use phrases that mean that we need to have expensive lawyers to help us interpret the clause? Why not just stick to plain English, which is what the amendment seeks to do?

Mr Burns: I will reply, and not as a lawyer. As the hon. Lady will understand, many of us have for a long time begged and prayed for legislation to be written in plain man’s and woman’s English. Sadly, it is not; we have not won that argument. As long as that is the case, we have to abide by the language and tone of legislation that has lasted us for generations. Not only do we have to go by precedent in drafting legislation, but we have to ensure that it achieves what we want it to achieve. I am confident that the phrase does that.

Karl Turner: Does the Minister not accept that the phrase itself is subject to interpretation? It is the type of thing that lawyers want to deal with. It is open to interpretation by people and lawyers.

Mr Burns: I am terribly sorry. The hon. Gentleman will have to tighten up in one or two ways. He said that there is no definition of outcomes in the legislation when there is, which suggests that perhaps he has not read the whole Bill. He now raises this point within three minutes of my reading out what it means in a legal form to lawyers. There is not the confusion or misunderstanding that he says there is.

Jeremy Lefroy: Will the Minister give way?
Mr Burns: Yes. Another lawyer.

Jeremy Lefroy: I am delighted to say that I am not a lawyer at all; I am a business man.

Is the Minister confused, as I am, about the meaning of the amendment? It would make the clause read, “The Secretary of State must seek to deliver the need to reduce inequalities.” I find it a little difficult to understand how one can seek to deliver a need. Perhaps he could enlighten me.

Mr Burns: First, I apologise to my hon. Friend. I do not know why, but I have it fixed in my mind that he is a solicitor. That was a dreadful slur; I withdraw the comment and apologise.

I share my hon. Friend’s confusion, highlighted by his reading of the clause as it would be amended by the Opposition. Fortunately, I am not responsible for their utterings, writings or draftings. If the hon. Member for Leicester West catches your eye, Mr Hood, and makes a further contribution in winding up the debate, my hon. Friend might be able to try to elicit an explanation from her.

I do not want to delay the Committee because the Opposition’s amendments, however well-intentioned—I do not question or doubt that they are—are neither needed nor necessarily relevant. The way we have dealt with the matter gives the Secretary of State adequate and totally all-embracing powers, as he wants to have to ensure that quality is the driving theme of these reforms. He, plus the board, the consortia and the providers, with the back-up of the health and well-being boards, HealthWatch and local authority engagement, will—together with everyone who works within the national health service—be focused on improving and driving up quality.

For that reason, I ask the Opposition, having probed a very important issue, to think again and consider withdrawing their amendment. If they are not prepared to do that, I invite my hon. Friends to join me in opposing their amendments.

Liz Kendall: I thank the Minister for his kind words about my speech. I shall, indeed, place a duty on myself to secure continuous improvements in my speeches as I go forward.

I shall be brief. We have not tabled the amendments for semantic reasons; we have done so because we are genuinely concerned to ensure that there are strong and clear duties to improve continuously the quality of services. The hon. Member for Southport has a lot of experience and I am very respectful of him and his opinions, but he questioned whether it is realistic to seek to improve quality continuously. If he does not agree with that particular point, why is the duty in the Bill?

We are concerned about quality. My hon. Friend the Member for Pontypridd pointed out that the legislation represents a weakening of the duty compared with previous Bills, which is why the amendments have been tabled. I say to the hon. Members for Southport, for North Warwickshire and for Stafford that the specific wording in the duty does not just relate to the Secretary of State; it is repeated for the national commissioning board and for commissioning consortia.

Hon. Members, particularly the hon. Member for Southport, rightly asked whether it is realistic to expect the Secretary of State to secure improvements in quality. Other hon. Members said, “Isn’t it down to the commissioning board or consortia?” I would say, “Yes, it is.” However, this is the same duty. They do not have a duty to secure improvements; it is to act “with a view to” and so on.

I say respectfully to the Minister that I am also thankfully—not “thankfully”; lawyers are fantastic—not a lawyer. The wording has changed in comparison with previous Bills, which is why we have raised the point. My hon. Friends and I think the measure still needs to be strengthened, not only in terms of the duty for the Secretary of State but in terms of the duty for the commissioning board and commissioning consortia, because somebody has to be responsible for securing improvements in quality.

John Pugh: My point is simple. If the hon. Lady is suggesting that the Secretary of State should have a duty to secure continuous improvement, presumably in her view it is always possible for the Secretary of State to improve any service continuously. In other words, it will never be okay, satisfactory or perfect. That is the kind of Maoist view of public services that I think her and I probably reject.

Liz Kendall: The hon. Gentleman raises an important point about whether a service can continuously improve. I differ from him in that I think services should and need to because health needs change. I shall give a brief example in relation to children’s heart surgery. I have a unit in my constituency, but I will not go into a review of that. Babies get born younger and younger because of technological advances. If they survive and they need congenital heart surgery, the type of surgery that is needed changes and evolves.

10.25 am

The Chairman adjourned the Committee without Question put (Standing Order No. 88.)

Adjourned till this day at One o’clock.