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**Clause 2** agreed to.

**Clause 3** under consideration when the Committee adjourned till Tuesday 1 March at half-past Ten o’clock.
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not later than

Monday 21 February 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES

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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)
† 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

(Afternoon)

[Mr Jim Hood in the Chair]

Health and Social Care Bill

Clause 2

Amendment proposed (this day): 36, in clause 2, page 2, line 23, leave out 'with a view to securing' and insert 'to secure'.—(Liz Kendall.)

1 pm

The Chair: I remind the Committee that with this we are discussing 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 (Leicester West) (Lab): To recap, the reason we have tabled the amendments is not semantics, but real concern that there needs to be clear and strong duties for the Secretary of State and, I remind Members, the national quality board and the commissioning consortia to improve quality.

My final point relates to what the Minister said about education, training and strategic health authorities. I am well aware that the Government are consulting on the proposed changes to education and training. My concern is that SHAs will be abolished under clause 28 before we know what is to happen in education and training. As that is so important to quality, I urge the Minister to be clear about the implications.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Will the hon. Lady explain what role SHAs play in training at the moment? I am not aware of any.

Liz Kendall: There is regional co-ordination on education, training and workplace planning. The deaneries are closely involved at that level. That point was raised with us by the junior doctors committee of the British Medical Association.

The Minister of State, Department of Health (Mr Simon Burns): The hon. Lady rightly raises an important subject. We all want to ensure that the highest standards of education and training are maintained and that, where need be, standards are improved. As she rightly says, consultation is ongoing. I assure her that the matter will be resolved before the SHAs are abolished, because we do not want any hiatus whatsoever.

Liz Kendall: On that point, I wish to press the amendment to a vote.

Question put, That the amendment be made.
The Committee proceeded to a Division.

Stephen Crabb (Preseli Pembrokeshire) (Con): On a point of order, Mr Hood. Will time be allowed for Members who are not here yet to arrive?

The Chair: Yes, the doors will not be locked for two minutes, or until the Whips have identified to me that they wish them to be locked.

The Committee having divided: Ayes 10, Noes 12.

Division No. 7

AYES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Smith, Owen
Thomberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

NOES
Brine, Mr Steve
Burns, rh Mr Simon
Burston, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

Liz Kendall: I beg to move amendment 38, in clause 2, page 2, line 33, leave out from 'show' to end of line 36 and insert—

'(a) the effectiveness of services,
(b) the safety of services,
(c) that services are patient-centred,
(d) the timeliness of services,
(e) the efficiency of services, and
(f) the equity of services.'.

I know that members of the Committee are keen to make progress, so I shall be swifter in speaking to the amendment than to the previous group.

New section 1A(3) of the National Health Service Act 2006, inserted by clause 2, lists three outcomes that the Secretary of State should seek to deliver when having a view and having regard to securing continuous improvements in quality: the effectiveness of services, the safety of services and the quality of patient experience.

Effectiveness, safety and patient experience are crucial elements of a high-quality service, but they are not the whole story. Amendment 38 would more clearly define the factors that make up a high-quality service.

Members of the Committee will recall that several witnesses who gave evidence last week emphasised how difficult it is to define and measure quality. My right hon. Friend the Member for Rother Valley rightly asked Stephen Thornton of the Health Foundation, Jennifer Dixon of the Nuffield Trust and Julian Le Grand of the London School of Economics,
"what evidence do we have...that quality is something that can be measured, something we can put faith in, as opposed to a target, and something that is going to improve services?"

The responses to that question are important when considering clause 2 and the amendment. Stephen Thornton replied:

"As everyone knows, quality in health service delivery is notoriously difficult to get your head around and to define."

He referred to standardised mortality ratios. Surely whether some is dead or alive is clear, but in fact, the point emphasised by Nigel Edwards was that it is difficult to get from those standardised mortality ratios a clear understanding of whether, for example, the issue is the case mix of a particular hospital. If a hospital deals with very difficult cases, its standard mortality ratio will be much higher. Dr Jennifer Dixon said that "quality is not very observable."

and Julian Le Grand, who, as I am sure Government Members know, is in many ways a champion of the Government's reforms, said that "it is so difficult to measure quality. To some extent, we have to rely upon inferring improvements in quality from changes in other areas."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 22-23, Q47.]

We need to look at inputs and processes as well as outcomes. That is rightly acknowledged in the Government's outcomes framework, which says that there is no pure outcomes-alone approach that we can measure all quality on. I am not going to repeat the arguments about why it is important to define quality, but I believe that the provision would benefit from greater specificity and clarity.

Members of the Committee will be aware that a huge amount of work has been done in this country and internationally on the different elements that make up a high-quality service. The most groundbreaking work was done 10 years ago by the Institute of Medicine in the United States. Its report, "Crossing the Quality Chasm", began the efforts to improve quality internationally and in this country. The Nuffield Trust report, “The Quest for Quality”, built on that report, and has been influential in shaping thinking, including that reflected in Ara Darzi’s report. Both reports identify six key areas that go to make up quality health services.

First, the reports specify safety, which the clause already includes, saying that care should avoid injuries to patients from the care that is intended to help them. The second element is effectiveness—in health care that usually centres around the need for services to be based on scientific knowledge, so that all who could benefit from them do, and to refrain from providing care from which patients are not likely to benefit.

The third element of quality is to do with care being patient-centred. I am sure that some people will again think that that is semantics. Patient experience is vital to measuring the quality of care, but a patient’s experience is not the only thing that makes care patient-centred. It is also about whether services are tailored to meet individual needs, whether they include the views and concerns of family members, and so on. Patient-centredness is a much better way of expressing those things.

The fourth element is that services should be timely. I am not going to open up a huge debate about waiting time targets and whether they are politically motivated; suffice it to say that the timeliness of services is vital to their quality. There have been big debates about the outcomes of cancer care and whether this country does worse than others. In fact, it is on the very first set of diagnoses that we often fall behind. Timeliness is vital not only in clinical care, but because patients want it—at the top of their list of concerns and priorities is the wish for care to be timely.

The fifth element of quality care—I am surprised that it has not been specified by a Government who are rightly concerned with spending—is the concern that services should be efficient and avoid waste, not only waste through bureaucracy but the waste of equipment, supplies, ideas and energy.

The sixth element of quality is that care should be equitable. It should not vary in quality because of a personal characteristic such as gender, ethnicity, geographic location and socio-economic status. I am sure that we discuss equality and the duty to promote it at greater length under the next clause. Although the new section 1A(3) that clause 2 would insert into the 2006 Act attempts to set out the key features of quality, I firmly believe that it does not go far enough.

A health care system that made improvements in those six key areas would be far better at meeting patients’ needs. If quality is really at the heart of the Government’s plans for the NHS, clause 2 should spell that out in greater detail. The clause says only that safety, effectiveness and patient experience are key to quality. I think that we should go much further, and amendment 40 would achieve that broader and clearer definition.

Jeremy Lefroy (Stafford) (Con): I understand the hon. Lady’s argument. She made several good points and the additional four aspects of services—that they should be patient-centred, timely, efficient and equitable—are all extremely valid. I would add two or three others; they arise from my experience at Stafford, but I think that all right hon. and hon. Members will be aware of them. I have in mind the importance of care, respect and dignity—particularly respect and dignity.

Reports this week have revealed many cases from around the country of insufficient respect and dignity for elderly patients. Although I have a lot of sympathy with the points made by the hon. Lady, and acknowledge that the wording of the Bill could perhaps be improved if I could think of the correct word—I cannot—the phrase “quality of experience” includes those softer aspects such as respect and dignity that are not included in the harder, more measurable outcomes that she has set out in the amendment. I believe that Bill’s wording encompasses more of what we want to see in quality of care, even though I understand her reasons for proposing the outcomes listed in her amendment, which I think are important and need to be taken on board by anyone involved in the health service. I am sure that Ministers are doing that.

1.15 pm

Mr Burns: Amendment 38 would reword and extend the definition of quality. In a way, this debate is linked to the one we had on the previous group of amendments and it picks up on the concern expressed by the hon. Member for Kingston upon Hull East, who before lunch accused the Government of not defining quality or outcomes in the Bill. It is quite clear that early in the Bill—on page 2, in fact—we have done so.
What is interesting, and the reason why I welcome the conversion of the hon. Member for Leicester West and her party, is that Lord Darzi was desperate for the previous Government to define quality and outcomes in primary legislation, but that was resisted by the Labour Government. In one way, we are all taking a giant step forward because we—certainly on the Government side of the Committee—recognise the need to put down a comprehensive definition, so that no one can doubt our commitment to improving and enhancing quality and to ensuring that we, with everyone else in the health service, work in that ongoing endeavour.

The duty to seek improvements in quality sits at the very centre of the Bill and the definition of quality used is the one that was agreed and embraced by both clinicians and the public during the next stage review of the NHS. I accept that Opposition Members are seeking to improve the Bill, but I fear that the amendment would do little to bring clarity to the meaning of quality. In fact, it would make extremely unhelpful distinctions. I know that they are not doing that deliberately, but there is always the law of unintended consequences. If the service is timely, it has to be delivered safely, effectively and in a way that improves the patient experience—it cannot be otherwise. Our definition of quality does not distort clinical priorities but supports our work on the outcomes framework. That is why our definition is the accepted one. It works, and it has the bonus of being recognised by both clinicians and the previous Government.

The three domains of quality—patient safety, patient experience and effectiveness—were identified following a review that was led by 2,000 front-line clinicians and other local health and social care staff, involving thousands more staff, patients and members of the public. Opposition Members will no doubt remember that. Given that the review was published in 2008, I suspect that the hon. Lady not only remembers it, but may well have been involved in the work leading to the publication of the review, as she had the distinction of being a special adviser to Patricia Hewitt in the Department of Health until the change of regime in June 2007. As she probably knows, the review concluded:

“If quality is to be at the heart of everything we do, it must be understood from the perspective of patients. Patients pay regard both to clinical outcomes and their experience of the service. They understand that all treatments are perfect, but they do not accept that the organisation of their care should put them at risk.

For these reasons, the review has found that for the NHS, quality should include the following aspects.”

It went on to name them as safety, experience and effectiveness—precisely what we have put in the Bill. Because the wording is all-embracing in many ways, it should go a long way to reassuring my hon. Friend the Member for Stafford, who made some extremely valid points about the patient experience and how patients feel about their treatment by the NHS. Extending and rewording the definition of quality would only add confusion to a principle that is understood, accepted and owned within the NHS.

For those reasons, I believe the changes proposed in the amendment are wholly unnecessary. The issues raised are of course important, but the Bill already places a duty on the Secretary of State to reduce inequalities, as well as duties on the NHS commissioning board and commissioning consortia to reduce inequalities, to promote patient involvement and choice, and to exercise their functions effectively, efficiently and economically. The duty to seek to improve quality would need to be considered alongside those other duties, although I find it inconceivable that there could be quality alongside inequality, inefficiency or a service that did not take into consideration the needs of its users. The Royal College of Physicians picked up on that point in its response to the consultation on the NHS outcomes framework, acknowledging that health care that is not safe could not be described as efficient, effective or sustainable.

The definition of quality is comprehensive and clinically owned. The amendment adds nothing. I ask my hon. Friends to vote against the amendment if the hon. Lady is not prepared to withdraw it. While she reflects, let me say that we are united with the previous Labour Government on the definition of quality and outcomes that we have chosen to put in the Bill.

Liz Kendall: I realise that the definition in the Bill was worked on by Lord Darzi, but we are concerned that measures in the Bill could threaten quality and that is why we feel that quality needs to be more clearly defined.

Mr Burns: Will the hon. Lady give way?

Liz Kendall: Let me make some progress first.

I am sure that the Minister did not mean to say that I and other Labour Members have somehow suddenly been converted to caring about quality in the NHS.

Mr Burns: I certainly did not. My point was that I was delighted that the hon. Lady had been converted to caring about quality in the NHS.

Liz Kendall: The Labour Government set up Lord Darzi’s review. We would not have brought him in had we wanted anything to the contrary. I do not want to debate the point with the Minister, but I hope that he will accept that we initiated that review because we wanted to improve quality even further.

Mr Burns: The hon. Lady has not quite understood my point. I was saying that Lord Darzi wanted the previous Government to put a definition in legislation, but they were not prepared to do so.

Liz Kendall: Mr Hood, I am sure you want us to focus on the amendments, which is exactly what I will do.

I want to make two other points. The hon. Member for Stafford rightly raised the issue of respect and dignity. I am sure we could go around the houses about the meaning of patient-centred care and the patient experience and so on. I simply want to put on record that I absolutely support him in wanting to achieve that goal.

My third and final point is to put on record for Government Members that quality is difficult to define, and outcomes are difficult to define. We had a brief debate about politically driven targets. I believe that the previous Government’s targets were always about improving quality and outcomes for patients, but there are different ways to get those outcomes. Sometimes we have to
measure what is called inputs, such as the time spent waiting for treatment, because the ultimate outcomes are often difficult to measure. It therefore respectfully urge hon. Members not to think that defining quality or outcomes is simple; it is a difficult process. The definition has to be as broad as possible if we want to improve patient care. On that point, I would like to press the amendment to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 13.

Division No. 8]

AYES
Abrahams, Debbie
Barron, r Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

Smith, Owen
Turner, Karl
Twigg, Derek
Wilson, Phil

NOES
Brine, Mr Steve
Burns, r Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Souby, Anna
Sturdy, Julian

Question accordingly negatived.

Liz Kendall: I beg to move amendment 40, in clause 2, page 2, line 39, at end insert—

'(5) In discharging the duty under subsection (1), the Secretary of State must ensure the people in a local area are consulted before significant changes to their health services.'.

The amendment provides that when Secretary of State is discharging his or her duty to act with a view to continuously improve quality, he or she must consult local people before any significant changes are made to their health services. The Committee has been given evidence, which it has been the experience of the NHS over the past 10 years, that achieving a step change in quality, particularly of hospital services and care, will require significant changes to the way services are provided. We know that, for many aspects of specialist care, the chances of patients surviving and doing so with fewer disabilities are greater in specialist centres—I refer to services such as stroke and trauma care and children’s heart surgery, with which I am closely involved. Changes to services at regional level will also be extremely important if the NHS is to meet the efficiency challenge set by David Nicholson, chief executive of the NHS.

A couple of witnesses last week mentioned stroke care in London, which was also raised on Second Reading by the hon. Member for Ealing Central and Acton (Angie Bray). I shall go into that in a little detail to explain what we are seeking to achieve through the amendment. As some hon. Members will know, NHS London, which is the strategic health authority for the capital, went through a controversial reorganisation of stroke care in which eight hyper-acute stroke units were established. That was very controversial at the time, but in just five months those specialist centres have more than tripled the number of patients receiving clot-busting drugs to the highest rate of any large city in the world.

It is estimated that that will save 400 lives a year, as well as significantly reduce the disabilities of people who survive a stroke.

1.30 pm

As I said, that reorganisation was controversial, but the strategic health authority worked hard to involve patients and the public, as well as clinicians, to achieve those service improvements. I do not want to go beyond the scope of the amendment, but when we get to the provision abolishing strategic health authorities later in the Bill, people will rightly ask how those big regional-level service changes will occur if there is no longer any kind of regional tier in the NHS.

As witnesses have said to the Committee, commissioning consortia could take on such a role if they work together across larger areas. However, witnesses, including Stephen Thornton, said that the Health Foundation has done a lot of research into the issue, with initiatives that have involved GPs in commissioning. That research shows that GPs tend to be better at making changes in out-of-hospital care—community health services and so on—rather than at the hospital level.

We also need to remember that commissioning consortia will not hold contracts with providers until April 2013. Strategic decisions that can improve the quality of care should be being made now, but they are being delayed because people are uncertain of what the reorganisation will mean.

I turn back to the amendment. If we are going to have a duty to improve quality continually—whether that relates to the Secretary of State, the national commissioning board or GP consortia—that will inevitably mean changes to services. Sometimes there will be very significant changes to services, such as the one I described in stroke care in London. Those big changes must involve patients and the public, as well as clinicians.

I have, perhaps wrongly, anticipated the point that will be made against the amendment. I know that further on in the Bill we will discuss the duty to involve the public and patients in more detail, but I hope that the Committee will see why including a duty for public consultation should also be identified early on, up front and at the top of the Bill, where this very important duty to improve quality is contained.

Mr Kevin Barron (Rother Valley) (Lab): On a point of order, Mr Hood. My understanding is that there will not be debate on this clause stand part. If that is correct, I would like to participate in the debate on the amendment. Or am I wrong?

The Chair: I will probably announce at the end of this debate that we will not have a stand part debate, because of the exhaustive discussion on the amendments to the clause.

Mr Barron: Thank you, Mr Hood. That is very helpful. On the issue of quality and the amendment that we are discussing, the Minister was right to say that the next stage review was the next stage on from where the previous Government had the national health service, to bring in a better measurement of quality.

I asked the Minister whether he had received any feedback from the pilot scheme that was taking place in the north-west. That pilot scheme was based on a United States health provider called Premier—a not-for-profit provider—and considered in great detail how we
could measure better quality in our system, as opposed to the quantity that we have been good at measuring for many years. I want to ask the Secretary of State—sorry, the Minister of State, although he may have some ambition—whether he can help me in relation to the clause and, in particular, subsection (4), which states:

“In discharging the duty under subsection (1), the Secretary of State must have regard to the quality standards prepared by NICE.

This will be crucially important if we are to advance a best practice in the NHS. Indeed, in the evidence we took last week, both the chief executive of the NHS and the Secretary of State spoke about improving quality by the use of National Institute for Health and Clinical Excellence guidelines.

In clause 218 (5) the Bill says that “A quality standard... must be endorsed by the relevant commissioner”.

I assume by that that the commissioner—whether it is a GP consortia or a national commissioner endorsed by the national board—will have to endorse the quality standard. That is my reading of it. I ask the Minister how that relates to clause 4, on duty as to promoting autonomy, which says that persons “exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in that manner that it considers most appropriate”.

So the Secretary of State has to take regard to it, and it must be endorsed by the relevant commissioners, but clause 4 tells us that commissioners do not have to endorse it—

The Chair: Order.

Mr Barron: Mr Hood, I will sit down now. I wonder whether the Minister—

The Chair: Order. We are discussing this amendment to clause 2. I ask the hon. Gentleman to speak to the amendment.

Mr Barron: I am talking about clause 2, new section 1A(4) of the National Health Service Act 2006, which you can see refers to clause 218 of the Bill, which states that “A quality standard... must be endorsed by the relevant commissioner”.

and how that relates to clause 4 of this Bill, that says commissioners have autonomy—there is a great contradiction in that. I may not have to debate anything on clause 4 if the Minister can tell the Committee what this means.

Nick de Bois (Enfield North) (Con): I will be very brief on amendment 40 that the hon. Member for Leicester West put forward. I listened very carefully and with great respect to what she said, particularly on the issues surrounding stroke care. My observation is that—certainly in the case of Enfield—there was not actually any consultation about the proposed changes to stroke care. This came about because the acute hospital chose not to apply to be considered and GPs were not consulted. That is the situation we are coming from, and it is worth registering that the extensive local democracy and accountability that appear later in the Bill will address the issue. I support local engagement but there is a wealth of clauses that address that—I was going to list them but frankly I do not think there is time.

Grahame M. Morris (Easington) (Lab): I am aware that there are time pressures so I will try to be disciplined and confine my remarks to the wording in amendment 40. I speak in support of this amendment, which essentially seeks to give some additional responsibilities to the Secretary of State in respect of responsibilities on consultation. As the Bill stands, the duties of the Secretary of State, if not entirely conferred or devolved onto subordinate bodies, could be weakened. Clause 2, subsection (1) says that the Secretary of State must act “with a view to securing continuous improvement in the quality of services provided to individuals” and indeed

“In discharging the duty under subsection (1) 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.”

This includes his public health functions, those functions the Secretary of State exercises in relation to the NHS and its commissioning board, and the GP commissioning consortia. The amendment would add a significant but fairly simple function that Members could support irrespective of party, especially given the remarks made by the hon. Member for Enfield North and his fellow Government Members on the need for full public consultation about various issues that affect the delivery of local health services.

As we know from our discussions on clause 1, the current duty on the Secretary of State to provide or secure the provision of services for the health service has in effect been removed. Opposition Members are, therefore, genuinely concerned that there might be a democratic deficit, whereby Members of Parliament of all parties are unable to hold the Secretary of State to account on issues related to the health service.

The amendment would strengthen democracy in the NHS, although not by far enough. It would ensure that the Secretary of State consults local communities where significant changes to health services are to take place. The function of the Secretary of State is to act “with a view to securing continuous improvement in the quality of services provided to individuals”.

So significant changes may well occur that affect services within or across communities.

As clause 2 addresses the Secretary of State’s duty to improve the quality of services it seems appropriate that, as part of the Government’s slogan or mantra, “No decision about me, without me”, there should be local involvement in service changes. I understand that we will be moving on to the issue of service providers failing, perhaps due to market conditions, later in our consideration of the Bill. Therefore, I do not intend to address it now, but it might exercise local communities that are considering these issues.

Where there are service changes, perhaps as a consequence of the Secretary of State, or a local authority acting on his behalf, seeking to secure improvements in outcomes, why should there not be a safeguard in place to ensure further accountability? My fear is that some
aspects of the Bill will in certain circumstances remove
the voice of elected officials such as Members of Parliament
and, by default, our constituents. So I would urge
Members on both sides of the Committee to support
the amendment.

John Pugh (Southport) (LD): The hon. Member for
Leicester West will probably be told by the Minister in a
few minutes that the amendment is redundant, which is
a common ploy when amendments are moved in
Committee. One could argue that the legislation actually
provides what the hon. Lady is seeking, it just does not
ask the Secretary of State to ensure that it is there. One
could also argue that there is something rather odd
about asking the Secretary of State to see that the law is
enforced, because one assumes that is what the Secretary
of State would like to do. The hon. Lady, however,
seems to have a point, so I will address what I think is
the real nub of the matter.

The amendment is work in progress. If the hon. Lady
wishes to move it on Report, it is probably advisable not
to press it to a Division now. She is suggesting that there
should be a level of consultation on regional services. It
is not obvious that the amendment applies exclusively
to regionally important services, but one can see why
people would want to be consulted on regional services.

The hon. Lady mentioned children’s services. She
might be aware that some time ago it was proposed that
Alder Hey, which is a significant children’s service in the
north-west, would move out of Liverpool. People have
a right to be consulted about such things, but it is not
clear what rights people currently have if such proposals
are made, or what rights they will have under the Bill.
Obviously, such matters would not necessarily be dealt
with by health and well-being boards.

There is a question about what voice people have
when services that might not be distinctly local—they
might be bigger than that—but are important to all
local people are subject to a reconfiguration proposal
of one kind or another. The Alder Hey case is one that
leaps to mind.

1.45 pm

The amendment does not focus sufficiently precisely
on that. It uses words such as “local area” and “significant
changes”, which obviously are debatable. What is a
local area, and what is a significant change? In dealing
with the legislation, we have to bear in mind when we
talk about local areas that the concept of area is up for
debate as well. At one time, under the primary care trust
arrangement, it was possible to talk about a health area
and a local authority area, but now the commissioning
units will not be area-based, and that problem will go
right through this legislation as we try to read through
the implications.

The hon. Member for Leicester West has a perfectly
valid point. I dare say the Minister will put us at ease in
respect of some of the issues that she raised, but we
need an explanation from him, in terms of the legislation,
of exactly what will happen when services of enormous
regional popularity and significance get modified in
some way. For example, what will happen if Alder Hey
decides in the future to move out of Liverpool and go to
Widnes, as it has said it may? What voice will the public
have, and how will it be expressed?

Owen Smith (Pontypridd) (Lab): My point follows on
from the one made by the hon. Member for Southport.
In essence, it is a simple point about strategic planning.
The amendment seeks to offer an additional safeguard
in respect of strategic planning, which is an aspect of
the NHS that we feel will be undermined as a result of
the changes being made elsewhere in the Bill, notably
the abolition of SHAs and PCTs.

The concern we have is that services may be reconfigured,
either as a result of changes in demand by GP
commissioning consortia determining that they want to
change the nature of the services, or the nature of the
provision that they can access locally—Sir David Nicholson
seemed to suggest in his evidence that that might
happen—or supply-side changes, whereby NHS trusts
determine that they want to change the nature of the
service that they offer, perhaps through merger or
reconfiguration in other respects.

Our concern is that the only way in which those
potential changes might be held up is if they are deemed
by Monitor, the economic regulator, to be in breach of
competition law. However, there may be other reasons
not related to competition law such as clinical reasons
or political, with a small “p”, long-standing views on
the part of the local population which lead them to
believe that it is important that services be locally held,
or that the current configuration ought to be maintained.

The amendment is simply about trying to put in an
additional safeguard, and, in keeping with the spirit of
localism that the current Government are so keen on in
this Bill and elsewhere, it simply seeks to ensure that the
Secretary of State observes that and makes sure that
local people have a say if the services that they deem to
be important to their local population are in jeopardy.
For that reason, I support the amendment.

Nicky Morgan (Loughborough) (Con): It is a pleasure
to serve under your chairmanship, Mr Hood. I was
stung into speaking by the Minister’s earlier comments
about lawyers and solicitors. As a solicitor, I have to
plead guilty. I was originally planning to speak about
the amendment, but about the words “significant changes”.
I spent many happy hours in my former career talking
about what is or is not a significant change, but I see
that the word “significant” is used later in the Bill, so I
shall not talk about that.

I want to make some brief points about the amendment.
I totally understand why the hon. Member for Leicester
West proposed it, but it is in the wrong place in the Bill.
My hon. Friend the Member for Enfield North spoke
about the other duties in respect of public involvement
later in the Bill which relate to the national commissioning
board and GP commissioning consortia, and I think
that that is the right place for patients to be involved in
service changes.

The hon. Member for Leicester West spoke about
reconfiguration occurring. That was recognised by those
who gave evidence last week, and strategic decisions are
currently being made. She spoke about heart services. I,
too, am a Leicestershire MP and am also concerned
about the future of children’s heart services at Glenfield
hospital. Speaking as someone who was very involved
in the campaign for the Loughborough walk-in centre,
which is an essential part of the health service in
Loughborough, my concern with the amendment is
that it states that
“the Secretary of State must ensure the people...are consulted”.

The trouble is, as the hon. Member for Easington said, that there is a semantic difference between consultation and involvement. I am sure that we will speak about that a lot when we deal with patient and public involvement, but consultation is not involvement—involvement goes wider.

My concern about consultation in this context is that it is very easy for the Secretary of State to say that people must be consulted, but as we have heard today—all power to the Government’s elbow in relation to the dreaded word “forests”—we have heard people, we have listened and we have changed what we are consulting on. We are to be congratulated for listening to what people have said. That is something new and refreshing in politics in this country.

Finally, the hon. Member for Pontypridd talked about localism. I do not think that the Secretary of State has a place in localism; the whole point about localism is that services are delivered and decisions are taken closer to people. That is why the patient and public involvement parts of the Bill will deal with the concerns of the hon. Member for Leicester West. We will discuss those further when we get to the relevant clauses.

Jeremy Lefroy: My hon. Friend the Member for Loughborough has covered most of what I wanted to say. I just stress the importance of going into some detail about public involvement and consultation later in our deliberations. There are some questions about what precisely public involvement and consultation means. Looking ahead, I see that public involvement can refer to being provided with information, and that alone. That, I believe, will not be sufficient. I rest my remarks there. I will not support the amendment, but the discussion will be important later, along the lines that my hon. Friend has pointed out.

Mr Burns: The amendment, as has become abundantly clear during the debate, would require the Secretary of State to ensure that local people were consulted before significant changes were made to their health services. We fully support the involvement of local people in shaping their local health and social care services; that is why we have put forward proposals to enhance significantly the role of councils and local authorities in relation to health services and to increase their local democratic legitimacy in health.

We want far more local involvement and for the voices of local people to be fully considered. I do not want to stray beyond the bounds of this narrow amendment into the whole area of reconfigurations, Mr Hood, unless you allow me to, because I know we will discuss it in great detail during our discussion of subsequent clauses.

The Chair: Order. I advise the Minister to follow his natural instincts.

Mr Burns: Mr Hood, I am very grateful for that ruling. I was hoping that you were going to say that, so that I would not get any trouble from Opposition Members.

The Government have done a number of things since last May and my hon. Friend the Member for Loughborough touched on one of them. When the Secretary of State was concerned that not enough consideration was being given to the views of local people and local clinicians with regard to reconfigurations, he strengthened the criteria substantially on any reconfigurations that had to go through, ensuring that when a consultation process is happening, those criteria are fully met before a proposal advances further.

To keep within your ruling, Mr Hood, I will stop there on that narrow point so that I do not explain the full procedures of reconfigurations in great detail. We will deal with those later. However, before coming back to the hon. Member for Rother Valley's overarching points, I will pick up one or two points raised by the right hon. Member for Rother Valley. First, he reiterated his point from an earlier debate about the north-west pilot scheme and what has been learned from it. I can tell the right hon. Gentleman that the North West Strategic Health Authority responded to the Department of Health's consultation on the outcomes framework, and the Department is working with them to share best practice and learning as we continue work to develop the outcomes framework. I hope that that helps to clarify the situation.

The right hon. Gentleman's other point was about the identity of the commissioner. In that context, the commissioner is either the Secretary of State or the board, but it could be both. In that context the commissioner is either the Secretary of State or the board, but it could be both. NICE provides a quality standard when asked to do so—on matters of public health or social care if asked by the Secretary of State, and on the NHS if asked by the NHS board—but both can ask for a care pathway. The standard is set when the Secretary of State or the board endorses it, which is right, as they are accountable to the service and NICE is not. I hope that that goes some way to helping the right hon. Member for Rother Valley.

On the more complicated and slightly distracting amendment to clause 4, I hope that the right hon. Gentleman will forgive me; I shall respond to him, but I would rather do so on clause 4, as I do not want to fall foul of you, Mr Hood, and wrongly expand our debate when we are dealing with a relatively narrow amendment to clause 2. I hope that the right hon. Gentleman appreciates that.

Mr Barron: I am very happy to do that. It seems a contradiction, given that we can visit the subject at a later stage.

Mr Burns: I give the right hon. Gentleman the assurance, provided we do not canter too quickly towards clause 4, that by the time we reach it there will be a great deal of clarification that I hope will explain the situation and reassure him.

A specific question was asked by the hon. Member for Leicester West, who wanted to know how regional changes will happen without strategic health authorities, and whether clusters of consortia can manage. I shall explain the first point. NHS commissioning boards will consult on specialist services. If the proposal covers a number of local authority areas, the commissioning...
board will consult all the relevant local authorities—as she would expect. If appropriate, the local authorities can establish a joint scrutiny function to consider the proposals.

Derek Twigg (Halton) (Lab): That is very helpful, but can we be clear about it? Why consult the local authorities if the collective view is that they wish to go a certain way? Would the board be bound by that decision?

Mr Burns: Let me get this right. If the board decided to go one way and the local authorities disagreed—

Derek Twigg: Yes, the Minister can put it that way as well.

Mr Burns: Okay. In that case, the local authorities could write to the Secretary of State, asking him to refer the matter to the independent reconfiguration panel. I believe that I am right, but if not I shall let the Committee know as soon as possible.

Derek Twigg: I accept that this is a detailed point. I do not have a problem with it, but I want to be clear. What I am getting at is whether the mechanism is in place. It does not seem to be. I know that the Minister needs clarification on the matter, but he seems to be saying that if a proposal goes out—it is not necessarily a review—even if all the local authorities in the region decide that they want to go another way they cannot overrule what the board has said.

Mr Burns: I do not need clarification. I now fully understand the point being made by the hon. Gentleman. If the board makes a recommendation, and if, after consideration, the relevant local authorities do not like it, they will have the power to write to the Secretary of State to ask for the matter to be referred to the IRP. [Interruption.] Let us not complicate it; that is the system. If the local authorities do not like the board’s proposal, they will have the opportunity to send it to the Secretary of State, asking him to refer it to the IRP. To all intents and purposes, that is what happens now. I hope that I have clarified the matter for the shadow Minister.

Derek Twigg: We may return to it later.

Mr Burns: I am sure that we will when we debate reconfigurations, but that will be the situation under the board.

2 pm

John Pugh: Will the Minister also clarify whether, in those circumstances, the board will be under obligation to consult in the first place? That would certainly be good practice and ideal, but is there a statutory requirement for it to do so when a significant change occurs in the regional services?

Mr Burns: Yes, there certainly is. The changes are coming, which may lead to some of the need for clarification, because of the establishment and the role of the board. There will be consultations with the affected local communities, local clinicians and, more importantly, the local authorities. The shadow Minister may like to hear this, because it is quite important. That is, however, in the context of designated services. He might want to reflect on that.

Following that diversion towards later parts of the Bill—we will be coming to reconfigurations in great detail later—the reason that I am not desperately happy with the amendment is that it would duplicate the existing duties on NHS commissioners and providers to consult patients and the public when considering changes to services under section 242 of the 2006 Act. We are amending those duties to apply them to the new architecture, including GP commissioners and the commissioning board.

I am sure that Opposition Members will agree that that is absolutely the right thing to do, because with reconfiguration of services at whatever level—whether designated services in the case of the NHS commissioning board, local service provision through providers or something consortia-driven—there must be local involvement and the views of local communities must be taken into consideration.

The proposal for duplicating section 242 of the 2006 Act is in addition to our proposed changes to section 244 of the 2006 Act, which will enable us to retain existing duties to consult with respect to local authority scrutiny on proposals for significant service reconfigurations of designated services and to extend, for the first time, the regulation-making powers to enable scrutiny of all providers of NHS services, including private and voluntary sector providers. I hope that putting that on the record will help the hon. Member for Halton, because he perked up when I mentioned the whole question of designated services. I am talking about regional reconfigurations of services.

Taken together, the current duties and proposed modifications in clause 175 already ensure that there will continue to be legal duties to consult local people on proposals for substantial service reconfiguration. To accept the amendment would be to add to the duties unnecessarily, and I urge the hon. Member for Leicester West to withdraw it. If she will not, I urge my hon. Friends to join me in rejecting the amendment. Although there will not be a clause stand part debate, I hope that hon. Members agree that the clause has had full scrutiny through the debates on the amendments.

Liz Kendall: The hon. Member for Loughborough has rightly said that some decisions about big changes to services are taking place, such as to children’s heart surgery. Those are the responsibility of the national specialist commissioning board, so it has not been affected by the re-organisation. My point was that there are some decisions, both at local and regional level—particularly about the much-needed changes to trauma services that I was involved with when I worked at the ambulance service—being put on hold because they are tricky and they are difficult. I am concerned about that with regard to patient outcomes.

The point about regional-level decisions is important. Indeed, the chief executive of the NHS, in his evidence—not to this Committee, but to the Public Accounts Committee and the Health Committee—has been pushed many times to say that they are looking at whether there
should be some kind of regional outpost of the national commissioning board. He, at least, recognises that there are going to be challenges with GP commissioning groups coming together to make a really big decision on issues such as the future of trauma services. So, we will come back to the issue of a regional tier, to improve quality and effectiveness, later on in the Bill.

I would like to return to a point made by the Minister. I do not want to stray, but it is important, because the Minister made it in his closing comments. At the moment, if local authority health scrutiny committees do not like a re-organisation, they refer it to the Secretary of State, and the Secretary of State refers it to the independent reconfiguration panel. I am not clear how what the Government propose is any different. We will come back to that point, but the Secretary of State has said that the proposals on patient and public involvement and local democratic scrutiny will transform patient and public involvement. The Minister has just said that the process will be exactly the same.

Mr Burns: We will go into that in far greater detail, but briefly, so that the hon. Lady will understand, there will be differences in reconfigurations at the local level that have been driven by providers or consortia. There will be a far greater involvement of local government, including the full council of the lead local authority voting on the views put forward by their scrutiny committees, in what shape or form it does. The structures and the procedures are more or less the same, except for a greater increase in the involvement of local authorities. The crucial thing that has changed already, which my hon. Friend the Member for Loughborough mentioned, is the change in the criteria, on 20 May 2010, that strengthened the rights and powers of members of the public and local clinicians in the consultation process, and having a check system to ensure that those criteria are adhered to during a consultation process.

Liz Kendall: The Minister may not know now, but may want to come back to me on that. Under those so-called strengthened criteria, would he like to tell Members how many of the proposals have still gone through, or how many have actually been stopped? Under the so-called strengthened criteria, how many proposals have actually been changed, or stopped, as a result?

Mr Burns: As the hon. Lady will be aware, there are a number of consultations being carried out at the moment. A number were carried out in the second half of last year, and they are still at different parts of the process. Off the top of my head, one has been referred by my right hon. Friend the Secretary of State to the IRP. I cannot, off the top of my head, think of any others at the moment. The process is still ongoing, because, as the hon. Lady will understand, the consultation and the rest of the process are quite lengthy, relatively speaking.

Liz Kendall: I thank the Minister for that response. I shall just make the point that the so-called strengthened criteria by the Secretary of State are in fact the criteria that many services have used. It would be interesting if the Minister set before the Committee, when we come to the relevant part of the Bill, all the issues that have been rejudged under those criteria and say whether any have been stopped as a result. I am not yet convinced—we will come on to this point—that any of the changes on public scrutiny and accountability will make a difference if, in the end, the local authority still refers it to the Secretary of State, who refers it to the IRP.

I believe the debate has shown the strength of feeling among Labour Members, and equally among Government Members, who passionately believe, as do we, that greater patient and public involvement is needed. I welcome the comments of my hon. Friend the Member for Pontypridd, and of the hon. Members for Enfield North and for Loughborough. I would particularly like to thank the hon. Member for Southport, who made some very good points about the amendment. He understood that the purpose of the amendment was designed to look at strategic services at regional level, and he made some good points about how it could be improved. I will not press the amendment, but I will bring it back for consideration on Report, to see whether it can be improved and strengthened, based on the helpful comments made by Members on both sides of this Committee. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 2 ordered to stand part of the Bill.

Clause 3

The Secretary of State’s duty as to reducing inequalities

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 5, in clause 3, page 3, line 4, leave out from beginning to end of line 7 and insert—

(1) In exercising functions in relation to the health service, the Secretary of State must—

(a) act to reduce inequalities between all the people of England with respect to—

(i) their health,

(ii) the benefits and quality of care they can obtain from the health service, and

(iii) their access to health services, and

(b) report annually to Parliament on his Department’s progress in reducing inequalities.

(2) For the purposes of this Act “inequalities” shall refer to differences between people based on—

(a) age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation;

(b) geographical variation; and

(c) socio-economic variation.’.

The Chair: With this it will be convenient to discuss clause stand part.

Emily Thornberry: After debating the principles of these amendments and of this clause, if we are not successful in achieving the changes we wish to make, we wish to move on to a number of other amendments that we would make instead.

This morning, the Minister prayed in aid Lord Clashfern and said that there were times when complex language was appropriate. I see his Lord Clashfern and I raise to
him Lord Denning, who was the people’s judge and was famous for his simply worded judgments, delivered in a Hampshire burr. Lord Chief Justice Lord Bingham said that Lord Denning was the best-known and best-loved judge of this or perhaps any generation. He was a legend in his own lifetime. The reason for that was, as Lord Irvine said,

“The name Denning was a byword for the law itself. His judgments were models of simple English which ordinary people understood.”

It is very important for this Committee when we are considering these matters—and I know m’learned friend, the hon. Member for Kingston upon Hull East, will agree with me—that, if we are talking about the law of the land, it should be in simple English that English people will understand. We should not be using language which is unnecessarily complex. That is the purpose of our subsequent amendments. However, I will be moving on to those later.

Equality is a principle of such importance that it brought many of us into politics. Our national health service is a manifestation of that commitment to equality. It is at the heart of the NHS. There is a belief that no matter who someone is, or from what background they come, they must be allowed access to the best care and treatment, and that treatment should be free. That is seen as idealistic, but may I join the Nye Bevan club again, and quote his remark that the “collective principle asserts that … no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means?”

That is absolutely right. Although it may be regarded as unfashionable to be idealistic, all the people I know who work in the national health service are idealistic. They want the national health service to work in this way and for us all to have equal access.

2.15 pm

The reason I begin with this broad sweep is that we have a fundamental concern that the legislation undermines equality and equality of access in the national health service. That is why we are completely against this measure. We are against the Bill in total and this clause in particular. If this is the clause that relates to equality, it needs to be a great deal stronger to hold back the difficulties that this Bill will introduce by undermining equality of access.

The King’s Fund has conducted an assessment of health care policies. It judged that the basic funding structure of the NHS—this is in an assessment of the NHS between 1997 and 2010—which has few financial barriers to accessing services, is broadly equitable, although the way in which services are arranged can create problems. For instance, there are fewer GPs in areas of greater need. Despite the public service agreement target, reducing inequalities in health outcomes, such as life expectancy and infant mortality, is proving hard. The targets based on closing the gap between poorer areas and average areas were abolished by the incoming Government in May 2010. If those targets had remained, they would almost certainly have been missed.

No one is saying that it is easy and no one is saying that it has been achieved, but we must continue to work at it. We argue that this measure is not helping in the absolutely vital work of the NHS of trying to equalise health outcomes. The fundamental problem is the way in which the Bill allows the market to walk into the middle of the NHS, thereby directly impacting on equality. The Government talk about patients having more information and being able to sit down with their GPs and making a choice about the most appropriate treatment. Perhaps that is some sort of working of the market. Perhaps, in some superficial way, patients feel that it is an improvement to be given proper information, to discuss it with a GP and to get the best choice and help that they can. For some groups, it may be effective. The difficulty is that it does not work for everyone. In fact, it can exacerbate the inequalities that exist at the moment.

Let me give another example. We all know that some foundation trusts are not as strong as others, but will this legislation, which will see people deciding to go to the stronger foundation trusts as opposed to the weaker foundation trusts, simply exacerbate the differences? As a foundation trust gets weaker, has fewer people going to it, generates less income and perhaps even goes bankrupt, what about its patients? What kind of equality of outcomes are they getting if they are going to a weaker foundation trust that continues to get weaker? What happens about GP consortia?

Emily Thornberry: The right hon. Gentleman must remember—he is in danger sometimes of forgetting this—that he is in government. It is his legislation and it is his Government who are attempting to drive the market into the centre of the NHS. It is not a managed market any more, but simply a market of a type that will undermine any equality of access to services that we have had until now.

Mr Burns: The hon. Lady asks about foundation trusts. Does she not remember that it was the previous Labour Government who wanted all trusts to be foundation trusts?

Emily Thornberry: The right hon. Gentleman gets too carried away, may I assure him that I will never give up my principles? My fundamental principle is an absolute commitment to equality. If Monitor were to have its role taken away, in terms of the support that it gives to financial trusts, and instead morphs into some kind of monster within the NHS that is pushing a market into the middle of the NHS, the Minister would not be defending equality of access to patients in the NHS, but instead, be doing the opposite. That is a great danger, and that is why we need a stronger clause than the one before us. It is not just me who is saying this. The Committee has heard from many witnesses, and much of the evidence, which I know the Committee listened to carefully, supports the arguments that I am making.

I have made the argument that a foundation trust may flounder. What happens to the patients who use that foundation trust? They will get an increasingly weak trust and increasingly bad health care. There is an additional problem if the GP commissioning consortium
[Emily Thornberry]

that covers someone’s area is not strong. Under the influence of the market, it would become increasingly weak. Who falls through the cracks? The most weak, the most vulnerable and those who will find it most difficult to move from one consortium to another. We will exacerbate health inequalities by promoting this measure.

If we go back to the picture of the patient sitting down with the GP who, with the additional information, can make a decision, what happens when the patient himself or herself is so sick as to be unable to simply sit down and make that free choice? We had the great privilege of listening to Jenny Bogle—the only patient who appeared before us—who, despite being diagnosed with terminal cancer, gave compelling evidence to the Committee:

“Speaking as someone who was diagnosed with ovarian cancer 18 months ago, I can tell you that when that happens out of the blue, you are physically ill, you have massive things to take on board, and however clued up you are, the last thing you want to start doing is quality controlling—trying to sort out which is the best hospital for you, or the best best treatment. You are not an expert, but you suddenly have to become an expert overnight. I am certainly convinced that I would not have been equipped to do that”.

Hon. Members will remember what an impressive women she was. For a woman who felt that she would have not been in a position to be able to exercise that free choice, that is very strong evidence. She continued:

“I am pretty convinced that my GP, who has seen very few cases of this, would have been in the same position. You just want to be confident that you are having the appropriate treatment. You do not want to have to start making complicated decisions. Choices about which hospital for convenience or whatever are fine, but what can be overstated is the ability of vulnerable people to be involved to such an extent and to take on what feels like a rather unfair responsibility to become an expert in a rare cancer overnight.” —[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 117, Q277.]

I could not have said it better myself.

Margot James (Stourbridge) (Con): I, too, was very impressed by that evidence. As the hon. Lady said, it was compelling. However, there are carers who can accumulate a large amount of expertise, given the amount of information that is available through patient groups, the internet and so forth. They are in the position to help the patient become more informed and able. Many patients want to take more of a role in the decisions affecting their treatment, beyond the choice of hospital and consultant and so forth. The hon. Lady rather underestimates the potential of patients, the public and carers in this respect.

Emily Thornberry: The point that the hon. Lady makes is a good one. If, by attempting to make my point powerfully, I seem to underestimate the power of some patients, I take that back, because I do not mean to do so. People with a long-term condition in a relatively stable state, such as those who live with multiple sclerosis for a number of years, can develop expertise. I have met MS sufferers and their carers who are experts in that condition in a way that some GPs are not. I understand that, and people can develop an expertise in other conditions, too.

The difficulty, as I am sure the hon. Lady is aware, is that there are other groups. People might have a mental health condition with a complex range of difficulties. They might not speak English as their first language; they might not be in secure accommodation; they might have alcohol problems; and they might have a chaotic lifestyle. The idea that such people can sit down with their GP and make a decision about the best outcomes of their care highlights my case. On the one hand, there might be someone with those conditions, and on the other there might be a university graduate who has MS, who might be supported by a family and be able to sit down with a GP and make such decisions. My point is that it is not fair—it is not equal.

Mr Burns: Can I explain the matter to the hon. Lady, because she seems to be getting lost in the mist of time? That is a right of choice that patients may not, on occasions, wish to exercise. Listening to her words flowing, it is a little difficult to understand her point when one remembers that she took part in a hard-fought election campaign in Islington last May on a manifesto commitment that stated:

“We will expand patient choice, empowering patients with information, and giving individuals the right to determine the time and place of treatment.”

Emily Thornberry: I am grateful to the Minister for raising that, because there is a misunderstanding, deliberate or otherwise, about our position. There are times when the public can make decisions on a managed market basis. For example, if a patient had a hernia condition, they might be able to sit down and talk to their GP. It is a completely different matter, however, to bring in a measure that relates to all care and drive it into the centre of the national health service. To release the NHS, to allow the market to affect everything, will mean that the protection that is needed for the most vulnerable, which comes with a managed market, is no longer available.

Dan Byles (North Warwickshire) (Con): The hon. Lady seems to be suggesting that if not everybody can exercise choice, no one must be allowed to do so. Is that her position?

Emily Thornberry: I am happy to repeat what I have just said. Before the hon. Gentleman spoke, however, I was trying to address the point that he has made. We need a market in some areas of the NHS, but it must always be managed. The Bill undermines that, and in doing so, it attacks the principle of equality.

Dan Byles: I thank the hon. Lady for letting me intervene again. She confuses the concept of market and any willing provider, and the concept of choice. It is about who is providing certain services on the one hand, and patients choosing where to go and whom they want to be treated by on the other. Although the two overlap, they are distinct parts of the Bill and what it tries to achieve.

Emily Thornberry: I am conscious that at this stage of the debate we should focus on equality, and although I am happy to continue the argument with the hon.
Gentleman, it may be veering down a different path. I have to say, as a glancing blow before I move on, that the Government parties seem to confuse the idea of democracy with shopping. Someone going to a GP and being able to make a choice does not in itself equate to democracy. The Bill’s weak provisions that relate to democracy do not help with equality, pushing up services or standards.

Dr Poulter: I am sympathetic to the hon. Lady’s important point about inequalities in health care. That is part of the reason for the Bill, which deals with such matters. She is discussing the way in which the Bill is further expanding choice and how that will undermine inequalities in health care. How does she equate that view with the previous Government’s choice and book system, and other measures that still stand in the NHS?

Emily Thornberry: If I may, without meaning to be unnecessarily tedious, I remind the hon. Gentleman, as I have reminded the Minister, that the Conservatives are in government now, and that we are scrutinising legislation, which the two parties are attempting to push through, that will have a radical effect on the health service. It is important to focus on that and on any problems that anyone may have, and to scrutinise the legislation in an honest and straightforward way, which is what I am attempting to do.

2.30 pm

Dan Byles: Will the hon. Lady give way?

Emily Thornberry: If the hon. Gentleman will allow me, I am conscious of the time. I have been on my feet for half an hour and am still on the first page of my notes.

Dan Byles: How many are there?

Emily Thornberry: A few. Moving on to some of the evidence that supports my case, we heard from Paul Jenkins, the chief executive of Rethink, who said:

“There is a whole strand here. I think we are all happy that there will be a group of consortia with knowledgeable and active GPs, who will do everything that we want. In a national health service, the concern is what happens in areas in which that will be the fantastic resource that they can be. In areas where they are less good, there is a potential vacuum.”—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 119, Q281.]

Those were the words of an expert on cancer care when she gave evidence to the Committee about the possibility of cancer care getting worse in certain areas as a result of the diminution of the standing of cancer networks in weaker areas.

We are talking about equality of access to absolutely vital services. I hope that the Government parties will take that important critique very seriously. They need to be confident that they can address it in the Bill. I suggest that they make it do exactly the opposite of what it does at present.

Jeremy Lefroy: I have great sympathy with much of what the hon. Lady is saying. The problem of inequality in the health service and the importance of equality are vital. However, I should like to press her on one thing.

In my experience and that of a lot of people, it is not so much the structures that lead to local inequalities, but the people involved and the professionalism, or otherwise, of—let us be frank—the PCTs or GPs. At the risk of making a speech, I would like the hon. Lady to comment on that and how her amendment would deal with it.

Emily Thornberry: The hon. Gentleman is absolutely right. We can talk and write about structures, but it is people who deliver health care. That pushes me back to the arguments that I was making earlier. We know that when a hospital is successful, it attracts people. When a cancer network works well, people want to work there. However, if the differences between good and bad become exaggerated by the market system introduced in the Bill, excellence will get stronger in some areas and weaker in others. The best people will know that it is not worth remaining in an area where a cancer network is getting weaker.

In the end, people are only people. They want to work with the best and deliver the best services; they do not want to come home at night and worry that their service is not as good as it should be and as they would like it to be. That is why I respectfully submit that we need more regional management of the health service than we will ever have if the Bill is passed as it is, to ensure that we keep the service together rather than allowing it to fragment and hoping for the best.

Jeremy Lefroy: Does the hon. Lady not see the point that the localism that the Bill seeks to introduce is a better protection against poor performance? Primary
care consortia are much more likely to keep a close eye on what their colleagues are doing than a more distant PCT, or even an SHA.

Emily Thornberry: Tempted though I am to tell the hon. Gentleman my ideal, I think that we ought to focus on what the Bill can and will do. Without the structures that have existed in the health service until now, we will be taking a risk that, for the sake of our constituents and NHS patients, we should not be taking.

I return to the further evidence. I do not wish to labour the point, but it is important. We heard from Paul Farmer, the chief executive of Mind. Even within the structures for which I have been arguing, there are times when things do not work. At the moment, NICE can write best practice and make recommendations, but there are times when GPs simply ignore it. Paul Farmer said rather elegantly:

“It is important, first of all, to recognise that we are not sitting in a world in which NICE-recommended guidance is universally utilised.”—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 118, Q280.]

Even now, when the attempt is made to ensure that certain standards are kept throughout the country, it does not work everywhere. If the service is fragmented, surely things will simply get worse.

In the end, GPs are the gatekeepers. They are in charge of the fund and will decide whether patients go to hospital. At the end of a financial year, if somebody wants a hip replacement and somebody else wants a new heart valve, who will make the decision and how will it be made? How will it be made equally, and who holds the reins? The Bill throws up such difficulties, which go to the heart of the idea of equality of access that are enshrined in our NHS and that it is incumbent on us to protect.

Dan Byles: That is exactly what happens now, but it is the PCTs that make the decision. Before Christmas, NHS Warwickshire started a policy it called “fast, slow, stop” because it saw a problem looming in its finances. It decided to slow down certain treatments and stop others altogether.

The George Eliot NHS Hospital Trust in my constituency is still offering certain procedures to people referred from Hinckley and Bosworth, but not to people who live up the road—because people from up the road come under NHS Warwickshire, whereas people from Hinckley and Bosworth come under another PCT. What the hon. Lady describes—“End of financial year, will we start slowing things down?”—is happening right now in NHS Warwickshire under the system that we inherited from her Government.

Emily Thornberry: The hon. Gentleman makes an important point. Of course, in the end, limitless money for limitless services will not be available. However, if the organisations or individuals commissioning services cover a small area and have a relatively small budget, the decisions that they must make at the end of the financial year will be more exaggerated and could be more extreme.

For example, a GP or GP commissioning consortium might suddenly find that two new families have moved into the area. I met a family yesterday that had two boys with extreme disabilities. If that family moved into a GP consortium’s area, that could make a huge difference to the money spent by that consortium. They are a lovely family, and no one would want to say that they are a burden, but they would make a great difference to the budget of a particular GP consortium.

If three or four such families suddenly moved into an area, or if, for example, a housing association changed its lettings policy and decided that it would only allow in people who had disabilities, who would have sufficient points to be able to be housed—this happens with many housing associations in areas of acute housing need, such as mine—we might find a concentration of people with disabilities living in particular geographical areas. That could have a great effect on a GP consortium’s budget. That is neither equal nor fair, and it is not what the NHS ought to be about.

Emily Thornberry: Anyone can see the point that I am about to make. The risk for a larger area, such as a PCT area with assistance from an SHA, is clearly not going to be the same as the risk for a fragmented system of many small GP consortia. On the one hand, the Government argue that there is a best size for GP consortia, and on the other they argue that they are not going to dictate to GP consortia what size they should be. The Government cannot have it both ways.

If the Bill is focused on measuring outcomes, and its success or failure is outcomes-based, what priority will be given if someone has a condition that does not have an easily measurable outcome? For example, if I was suffering from schizophrenia and went to see my GP, they would not, no matter how hard they tried, be able to cure me of it. There would not be a box that said, “That is an outcome.”

My schizophrenia could be managed, but that is not the same as an outcome. In those circumstances, if a GP is trying to commission things and focus on outcomes, then people who have conditions that do not involve dramatic changes or outcomes are in danger of being pushed down the priority list.

The Chair: Order. When I can hear hon. Members going on as they have been, they are out of order. I invite hon. Members to pay attention to the Member who is speaking to the amendment.

Emily Thornberry: Thank you, Mr. Hood. The Opposition are not alone in having concerns about the impact of the changes on equality in the NHS. On Tuesday, The Guardian contained the headlines, “Liberal
Democrat cracks appear over NHS reform plans”. The second paragraph of that article states:

“Party critics claim the reforms will increase health inequalities”.

One critic, Charles West, a GP—and, incidentally, a former Lib Dem parliamentary candidate for Shrewsbury—said:

“’I am loyal to the Liberal Democrats, but I also love the NHS, and these reforms go in the wrong direction. The NHS needs improving, but the record shows it is not in the state described by the coalition, as authoritative institutions such as the King’s Fund have shown.’ He said patients with some of the most difficult health care requirements, such as elderly patients with multiple...conditions, were likely to benefit the least from a competitive market.”

He is concerned, like us all, about the effects of such reforms on equality and equality of access—particularly for the most vulnerable, who are not likely to be able to advocate for their needs as well as others. That is why the chair of the Royal College of General Practitioners, Clare Gerada, gave the very important evidence that hon. Members heard:

“We are concerned that the Bill risks widening health inequalities and could lead to worse patient care, and that introducing competition based on price will reduce quality.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 43, Q94.]

She could not have said it more clearly. It is important that hon. Members on the Government Benches hear this. I also refer to Karen Jennings, the assistant general secretary of Unison. She spoke of the danger of “two-tierism” as a result of the Bill.

2.45 pm

Perhaps the advocate who Government Members will find most compelling is the BMA. It said, on a different point, that if in making decisions the easier conditions and patients are focused on rather than the more difficult patients with complex needs, there is a danger that cherry-picking treatment for the less complex conditions will destabilise other provision, so the treatment of more costly, complex and time-consuming conditions becomes unsustainable or significantly reduced. How bad does it need to be? The arguments and evidence that hon. Members have heard on this is alarming.

Finally, I move on to the specific points in the amendment. Given the dangers inherent in the legislation, equality provision must be much stronger than it is. Frankly, we have come a long way on equality legislation. After the Equality Act 2010, passed by the previous Government, it is surprising that the clause deals with equality in such a “wave of the hand” fashion. I am sure that that was unintentional, but it is important when dealing with equality that the benefits are spelt out better than they are in the Bill. Inequality is such an important subject that we can do better than this.

One reason why we particularly wish to spell out in the Bill the different groups whose inequalities we ought to focus on is the treatment of the elderly, which is an important criterion in the past?

Emily Thornberry: I do not want to sound like a cracked record, but the hon. Gentleman needs to remember that his party is in government now and we are scrutinising the Bill that is before us now. It is very important that we do not get distracted by party political point scoring, because without sufficient focus we could allow a Bill such as this to pass, which will radically undermine our NHS. [ Interruption. ] Spending time scoring points in this way is, frankly, beneath the hon. Gentleman. I have a great deal of respect for him and we have worked together on all-party health groups for some time, so I know him well.

Please can we move on and focus on how elderly people are not treated fairly or equally as things stand in the NHS? How much better will it get under the Bill? We need to focus first and foremost not on structures or party political point scoring, but on how the Bill will help patients. How will the Bill help patients to be treated more fairly?

We all heard the evidence coming out from the health ombudsman. For the Health and Social Care Bill to achieve more positive health outcomes, it must be explicit that improvements are to be achieved across a whole population. We know that older people’s needs are often under-prioritised and under-recognised in the NHS. We also know that ageism in clinical practice persists, with older people often lagging behind other groups in terms of better health outcomes. A clear obligation is needed in the Bill to demonstrate that improvement is being achieved across a whole population. That is what the amendment is about.

For example, despite improvements in cancer outcomes, a 2007 study of breast cancer patients in Manchester found that older women are less likely than younger women to receive standard management for breast cancer and are less likely than younger women to have surgery for operable breast cancer, even after accounting for differences in general health and co-morbidity.

The health ombudsman’s recent report showed terrible failures in the care of older people. Of the 9,000 complaints to the ombudsman about the NHS last year, 18% were made about the care of older people. The ombudsman accepted twice as many cases for investigation about older people as for other age groups put together.

The aim of amending the Bill in the way proposed is to ensure that the Secretary of State’s duties are clear and specific, that he has a proper focus on the elderly and that people across England can be sure that their access to health care, and the quality of the health care that they receive, will be assured regardless of who is providing the service.

The areas where the Secretary of State can demonstrate improvement to reduce inequalities should be balanced and fair in their focus. Otherwise, the risk is that commissioners across the NHS will be incentivised to invest their efforts in improving health outcomes for those groups for whom they believe they can make the easiest and quickest gains. I have made that point before. It is easier to deal with a bright, alert, fairly compos mentis patient with one specific condition than it is to deal with some of the more complex needs that, frankly, most of us will develop as we get older.
**Dan Byles:** The hon. Lady has been very generous about giving way. She seems to have given us a litany of Labour’s failures in dealing with elderly patients during the last 13 years. Is that not a classic example of why the Bill, which seeks to drive up quality across the board in the health service, is so important and why simply sticking with the status quo in relation to structures and everything else that the Opposition want to do is the wrong way to go?

**Emily Thornberry:** The hon. Gentleman’s point is like a curate’s egg—good in parts. I do not think that any Labour Members have ever claimed that we left the national health service in a perfect state. It is not perfect, but it is so much better than it was when we inherited it. We were doing the right things. There is much more work that needs doing, and we would certainly wish the Government to build on our many achievements.

Some of the Government’s initiatives—for example, the mental health strategy and the cancer strategy—we have been pleased about on the whole, because they have been building on our achievements. The difficulty is that it is all very well having strategies of that sort, but they are only strategies for the short term, because in two years’ time, if the Bill is passed, we will all be heading over a cliff together. There will not be the levers any more for those sorts of strategy to be able to continue. That is the concern, and it is very serious.

No Labour Member has ever said—or they should not have—that the elderly were treated as well as they should have been in the national health service. Of course not. Of course much more work needs doing, and frankly there is a great deal of cross-party agreement on what should be done. The question is really how we do it. We believe that the Conservative party is fundamentally misunderstanding how it can be done and how we can drive up standards.

Leaving the national health service to the market is not the way to improve standards for everyone. It may be for some, but not for everyone, which is why I am making a speech on equality. Our NHS is based on the principle of equality, which is fundamentally at odds with the principle of introducing the market and allowing a free market that is not managed in relation to services across the piece.

I am sure that the Committee will be glad to hear that I am about to finish my speech. Before I do, may I return once more to the statement from the BMA? The Government have often cited the BMA as a supporter of the Bill. However, the BMA has made many important criticisms of the Bill that are not a laughing matter. [Interruption.]

**The Chair:** Order.

**Emily Thornberry:** The BMA said that it would like to see provision in the Bill for any new manifestations of health inequalities that arise as a result of reforming the way in which the NHS will commission services, particularly at a time of huge pressures on financial and public finances to be addressed. It said that there must be mechanisms in place to ensure that, if the range of services commissioned by consortia varies to such a degree that patients living in one part of the country are severely disadvantaged in comparison with those living in another, the NHS commissioning board has the ability to work with consortia to address such inequalities. The BMA added that those should include consideration of adding new services to the list of those that are more appropriately commissioned at a national level.

If the Bill is passed and inequalities do arise, is there anything in this provision? Are the Government prepared to look at any additional safety nets to ensure that those who have the misfortune of having a GP in a relatively weak consortium within a disadvantaged area, where their lives could be shortened, are also being properly looked after by the NHS?

**Margot James:** I am pleased that the hon. Member for Islington South and Finsbury finally got round to talking about older people in respect of equality of delivery of health care, because that was the topic I wanted to address. Before I make a few points on that matter, I should say that the main reason why I oppose the amendment is that the clause as currently drafted is a succinct summing-up of the fact that the Secretary of State should have a duty, as far as possible, to deliver equality. We do not need to spell out all the various groups that we should bear in mind that do not have equal access to health care.

**Liz Kendall:** One reason why the former Government introduced the single Equality Act 2010 was to try to get a level playing field between many different groups whose needs had not previously been met. One challenge of promoting equality is to understand the very different needs of different groups. Will the hon. Lady agree that sometimes—particularly with groups ignored in the past—specifying them might help focus attention on them?

**Margot James:** I do agree that by looking at groups individually as the hon. Lady suggests, one can sometimes develop a better understanding of why access has been unequal in the past, and what can be done to improve matters. I do agree with that, but I think the equality duty set out on public bodies now should make that intrinsic to the governance of the NHS, as it would with any other public body.

**Liz Kendall:** My experience of working with NHS organisations is that unfortunately they often do not understand the very different needs of different groups—either those for whom care is provided or those who work for them. I have been involved with training, for example, to promote people from different ethnic minorities within the NHS. That is a real challenge for what is still often a “white cat” service. We need to bear that in mind.

**Margot James:** I respect the hon. Lady’s point of view, but my experience as a director of an NHS trust—although some time ago—does not bear that out. Considerable effort was made in my trust to enable the promotion of BME candidates within it, and an understanding of the needs of BME patients. Of course, things can be improved throughout the NHS and all public bodies, but I draw the hon. Lady’s attention to the fact that the clause states that the Secretary of State’s duty is to “have regard to the need to reduce inequalities”.
among the various groups of people with whom we are now well versed. When exercising that duty and improving inequalities of treatment, surely my right hon. Friend will have regard to the points made by the hon. Lady. Under the Bill, we are devolving power and decision making throughout the NHS, and thus devolving responsibility, so it is not necessary to include in the Bill the needs of different groups.

3 pm

The point that I really wanted to make was about the care of older people and their equal access. The hon. Member for Islington South and Finsbury made several good points and drew on some examples, and I want to add a few more by considering access to treatment since NICE was introduced. Older people had to wait years before NICE agreed that the treatment of dementia in the early stages could be benefited by the Aricept class of drugs. For many years, older people suffered that discrimination. When a new treatment was licensed for macular degeneration, older people were not able to access it to many years. Those in certain parts of the country went blind waiting for the treatment. I shall not give further examples, but believe me there are many more.

Liz Kendall: I agree with the hon. Lady that such waits are unacceptable. Does she agree, however, that waits of more than three years for cataract operations, hip operations and knee operations, which is what many older people faced in 1997, were also unacceptable, but such long waits were completely eradicated under the previous Government, while waiting times as a whole were down to an absolute maximum of 18 weeks?

Margot James: I seem to be agreeing with the hon. Lady quite a bit, but I wish to point out certainly in respect of cataracts that improvements in waiting times were brought about only by the introduction of competition into the system, more of which will be enabled under the Bill. I trust she will agree that we might see even more improvements to even more conditions due to the introduction of greater competition and choice within the system.

I want to conclude by echoing the remarks of my hon. Friend the Member for Central Suffolk and North Ipswich, who said that some issues can be addressed only by looking at the funding formula. I understand Opposition Members’ point that we are in government now, but we have inherited the situation whereby the equality agenda of the Labour Government was so biased towards helping the areas of the country where people were subject to higher deprivation and of lower socio-economic status, and we can all sign up to having to deal with health care inequalities, in particular in certain parts of the country, another important issue is dealing with the fact that older people, and their specific needs, consume a larger proportion of health care. Such conditions include, among others, chronic bronchitis, emphysema and many others directly related to the work environment. It is not strictly true that ill-health is largely down to lifestyle choices.

Margot James: I thank my hon. Friend.

Owen Smith rose—

Margot James: I have concluded my points so, rather than give way again, I suggest that the Opposition Members make their speeches.

Grahame M. Morris: I feel passionately about this problem, which impacts directly on my area, as I indicated. I remind the Committee of the wording of the clause: “the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.”

Personally and politically, I strongly support the need to place a greater duty on the Secretary of State to reduce such inequalities, and that is exactly what the amendment does.

I draw the Committee’s attention to the evidence given by Stephen Thornton, the chief executive of the Health Foundation, in our first sitting. He called for a similar duty to be placed on the NHS commissioning
board and on the GP consortia, so as to embed shared decision making in all care and treatment, in order to tackle health inequalities.

Clause 19 is relevant to amendment 5. It places exactly the same duty as clause 3 does on the Secretary of State — having regard to the need to reduce inequalities — on the NHS commissioning board. As a marker on the consistency of the Bill, we might look to strengthen that clause in the same way as we propose doing to clause 3 with amendment 5.

The Committee should understand why the need to strengthen the obligation to reduce inequality is important. The justification for the amendment is that the new structures move away from the more co-ordinated, integrated service and towards a competition-based service where in some circumstances, failure is considered necessary or desirable to improve services. [Interruption] I see the Minister is pulling a funny face, but I refer him to the evidence given by Chris Ham in our second sitting. It is a contentious point, but in his view it was good to have some instability in the system. The fact that instability will arise out of this competition-based system is a factor we must take into account. It may have a deleterious effect on health inequalities and provision.

In its evidence, the BMA called for a co-operative and co-ordinated environment that a fully open market would make impossible. Dr Clare Gerada, chair of the Royal College of General Practitioners, during our second evidence session, expressed a number of serious concerns

“about the duplication of care and fragmentation...about the under-provision of care once competition starts kicking in, the pace and extent of change, and the capability capacity and competence of GPs”

to deal with the extent of health needs. Most importantly, she said that

“the Bill risks widening health inequalities and could lead to worse patient care,”.[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 43, Q94.]
it is certainly very welcome and should be welcomed by everyone, even though some might not agree with the methods that the Government will use to achieve it.

Research this week has shown that inequalities are not getting any better. There has been some research by Margaret Whitehead, professor of public health, on the north-south health divide that might be of interest to the hon. Member for Easington. She has established that health inequalities between the north and the south are worse than at any time in the past 70 years. That has happened under a number of Governments, all of whom have tried to address the issue. The 1997 Labour Government had a cross-departmental group working on health inequalities but, contrary to what the hon. Gentleman said, Labour has not had a great deal of success. It has raised the overall standard of the nation's health, but inequalities are just as severe as they ever were. It is not just that “it’s grim up north” – the causes are deep-rooted socio-economic ones as well as purely medical and clinical, which is why the inequalities have persisted despite huge improvements in medical facilities and GP practices. It is genuinely not an access issue; the most deprived part of the borough in which I live has the best access to health facilities.

Liz Kendall: I am sure that the hon. Gentleman is aware of research by Dr Julian Tudor Hart, which has shown that people in the poorest areas have the poorest access to health care. The previous Government did a great deal to improve access with, for example, their programme to tackle under-doctored areas, under which GPs – into whose hands £80 billion will be going – who tended not to go into poor, deprived areas were brought into them. Does the hon. Gentleman seriously suggest that there is no evidence that people in the poorest areas also have the poorest access to care?

John Pugh: I can only judge from the local point of view. I live in the borough of Sefton. Bootle has better access to health services than does my constituency of Southport, but outcomes are better in Southport. There is no direct correlation between good access and getting rid of inequities, but there is a perfectly valid point that the attempt to performance-manage GP practices, particularly in poor areas where a number of practices were not up to the job, produced real benefits.

Grahame M. Morris: I am not certain whether the hon. Gentleman is arguing that we should not be applying resources to areas of greatest need. We have some excellent examples. Sir Derek Wanless, who championed the idea, and Professor Townsend before him, spent a good deal of time on it. We have an exemplar in my constituency of Southport, but outcomes are better in Southport. There is no direct correlation between good access and getting rid of inequities, but there is a perfectly valid point that the attempt to performance-manage GP practices, particularly in poor areas where a number of practices were not up to the job, produced real benefits.

Liz Kendall: That is precisely what the amendment is designed to do – it addresses inequalities in three areas: access to services, the outcomes from those services and underlying health inequalities. Opposition Members are not arguing that it is simply about improving access to services. For the record, I can tell the hon. Member for Central Suffolk and North Ipswich that although the funding formula covers poverty and deprivation, it also includes specific criteria on age and rurality. It would be wrong to suggest that it does not include age. It is about striking a balance between these factors. Indeed, the Labour Government instituted a review of the funding formula for precisely those reasons.

John Pugh: I do not disagree, but we could discuss the funding formula ad nauseam. The Secretary of State made the perfectly valid point that unless we ring-fence public health funding, it can be lost among other funds and therefore not given the priority that it deserves, but it is essential when dealing with health inequalities.

I return to Margaret Whitehead’s research. Having done more research than any of us, she discovered that GPs were central to the task of improving public health and dealing with inequalities. She also discovered that causes are not wholly clinical but can be social and economic. The hon. Member for Easington made that point well. Following on from that is the fact that if the job is going to be done properly, GPs cannot simply absorb themselves from the public health agenda. They have to be involved in co-operating with a range of other bodies. For existing GPs, that will be a sharp learning curve, and I am not entirely certain how welcome it will be.

Margaret Whitehead also established the fact that increased choice in NHS services does not proportionally benefit those who suffer the worst health and who have the worst health outcomes. They tend to be less adequate when making choices on health provision. Another of her conclusions reinforces the point made by the hon. Member for Leicester West. In their new commissioning role, GPs will be hampered by the loss of the ability to plan for a whole population in a defined geographical area. That will be as a result of switching from primary care trusts, which are based on area, to registered patients, who may live all over the shop—not too far away, but not concentrated in a specific area. In order to address health inequalities well, the commissioning process needs to have a population perspective. That largely reinforces the point made by the hon. Member for Leicester West. In conclusion, it is an intractable problem and if we
have not got on top of it in 70 years it is not going to be easy to solve and certainly there is no magic bullet to deal with it.

**Emily Thornberry:** I have listened carefully to the hon. Gentleman’s very interesting contribution to the debate. Given what he has outlined, does he think that this Bill will help?

**John Pugh:** My conclusion is that the problem is indeed intractable, but it is not obvious how this Bill makes it less so. [Laughter.]

**Debbie Abrahams** (Oldham East and Saddleworth) (Lab): May I echo some of the remarks that have been made by the hon. Gentleman and by my hon. Friend? I also want to take this opportunity to clarify the point that has been made about previous policies of the former Labour Government. There is a difference between the wholesale marketisation of the NHS, which this Bill is trying to achieve, and the impact that it will have on inequitable access to care, compared with the addition of capacity and value. It was not an ideological decision to involve the private sector in health care provision for the NHS under the former Administration. However, there is a real difference. In my experience, both as a public health specialist and as a former NHS chair, the implication is that health becomes a commodity.

**Nick de Bois:** As the hon. Lady has opened the door to talking about the past, it is rather hard for me to resist pointing out that when Labour was looking forward at the last general election it talked about “any willing provider” in its manifesto. I am struggling to see the difference.

**Debbie Abrahams:** Under the former Secretary of State for Health, we also talked about the NHS as the “preferred provider”. That was absolutely clear.

**Mr Burns:** Will the hon. Lady give way?

**Debbie Abrahams:** No. I want to continue if I can.

**Mr Burns:** Oh, go on.

**Debbie Abrahams:** In a minute.

I welcome the fact that health inequalities are a high priority and emphasised in the clause. However, the provision is very woolly. That was said during our evidence sessions—the clause is particularly woolly. For far too long, we have not had the right focus to tackle health inequalities. The Black report is where health inequalities were first described in terms of the inverse care law. That report showed very clearly the relationship between health inequalities and deprivation. Then there was another report, “The Health Divide”, which a former colleague of mine at Liverpool university majored on. That has also been referred to. We know that those people who need care do not receive it. That is still being perpetuated and we want to ensure that the Bill and particularly this clause can redress that issue. Ultimately health care is a key health determinant. It affects not only our ability to receive care but our health outcomes. According to the Government, we are focusing on health outcomes.

In my own constituency of Oldham East and Saddleworth, there is a difference of 10 years—10 years—in life expectancy between the richest and poorest people. These are neighbours—

**Mr Burns:** We had 13 years of Labour.

**The Chair:** Order. I am trying to discourage heckling from a sedentary position. I think that we should expect better from the Minister.

**Debbie Abrahams:** Thank you very much.

What we are trying to do is to ensure that the Bill does not make the situation any worse. We want to achieve some traction, but as the Bill is couched that will not happen. That is not the mark of a civilised society—it really is not. We need to ensure that what we include in the Bill seeks to address these inequalities. We have discussed older people, but we know that children born to poor families are twice as likely to die as children born to rich families. Forget lifestyle; they are babies, and they are twice as likely to die as children born to rich families. No law of nature decrees such things. They are systematic inequalities that are socially produced, largely by ill-conceived public policy, including health care policy, and they are unfair. In his recent review, Professor Michael Marmot noted that people with a university degree are likely to live longer and in better health, estimating that if everyone over 30 had a degree, there would be 200,000 fewer deaths every year. That is an important point, and we should grab hold of it.

3.30 pm

I urge the Committee to support the amendment. It does not include, as I would have liked, the need to recognise the differential distribution of the impacts of public policy. The Secretary of State has a new responsibility for public health and it should take into account inequalities in access to care. The clause refers to benefits that for public health and it should take into account inequalities in access to care. The clause refers to benefits that people “can obtain” from the health service, but many of them do not do so. We must ensure that the language used addresses that problem. I urge Committee members to support the amendment.

**Owen Smith:** I rise in a spirit of mutual support and reciprocity, the ethos underpinning the NHS, to agree with much of what the hon. Member for Southport said. Inequality is a fact of life in the NHS. It is an intractable problem, and it has been for a long time. The same high quality of treatment is not always available everywhere in the country. That is a fact of life.

The Minister implied from a sedentary position a moment ago that the Labour party ought to say sorry for the fact that we still have health inequalities in this country. Members from all parties regret the fact that health inequalities still exist, but that is not for want of trying on our part. We tripled spending on the NHS from £30 billion to more than £110 billion; we radically increased the number of doctors and nurses; and we built hospitals the length and breadth of the country, as the Government whom he now supports did not when they were last in office.

**Mr Steve Brine** (Winchester) (Con): The last Government tripled spending on the health service, for which I give them great credit, and introduced the current structures,
yet we still have the problems that the hon. Member for Oldham East and Saddleworth described. What does that tell the hon. Gentleman? Perhaps it is time to try something different. [Interruption.]"}

Owen Smith: It certainly does not tell me that the answer is to privatise the NHS and let the market wreak its destruction. That is what the Bill will do.

I also agree with the hon. Member for Southport that it is positive that the Government have included the duty in the Bill. It is novel for a Government to place on the Secretary of State a duty to tackle inequalities, and it is a useful addition. However—here I agree entirely with my Front Benchers—that duty, summed up by three and a half short lines in this 300-clause Bill, is utterly insufficient to offset the impact of the other principal measures in the Bill, all of which mitigate against reducing inequalities, and it will increase them. I will highlight three, the first of which is the abolition of primary care trusts and strategic health authorities. Imperfect those bodies may be; however, they constitute a level of strategic national and regional planning designed in part to offset some of the inequalities in the system and level out the NHS to ensure more equitable distribution of health care and resources. That will be made more difficult by their abolition.

Julian Sturdy (York Outer) (Con): I think that hon. Members from all parties agree that we must reduce health inequalities. The hon. Gentleman is right to say that that is difficult to achieve, but does he actually believe that PCTs reduced health inequalities under the Labour Government?

Owen Smith: Yes, I absolutely do think that. Regional planning is vital to ensuring that we try to even out the imbalance that will occur, especially if vast volumes of NHS resources are placed in—this is the second point I was going to come to—untried, untested new vehicles led by GPs—[Interruption.]

The Chair: Order. It is bad enough getting interruptions when Members are speaking, but when conversations are going between two Front Benchers, I am just not having it.

Owen Smith: The third point I want to make about the mitigating impact is the idea at the heart of the Bill about liberating clinicians and other actors in the health care system and giving them greater autonomy to take advantage of the creative destruction—as one of our evidence givers described it—of the market in health care, thus allowing them to see whether that gives them more or less innovation. What the Bill will give them is more or less divergences in health care. Ministers accept that and have repeatedly said—the Secretary of State has said this in another arena—that there will be postcode prescription and postcode lottery of provision. That is presented as a good thing because we are told that it will be more reflective of the fact that local services are being determined by more locally held budgets and more local understanding of the needs of communities.

If I believed that that was necessarily what will derive from the Bill, I would support it. However, it requires a leap of faith that GPs will necessarily understand all the needs of their local communities better. We heard earlier remarks about the potential for a lack of understanding, which we already have in bits of the NHS, of the needs of particular parts of our community—for example, black and ethnic minorities. Why should we believe that GP consortia will be any more perfect than current vehicles at responding to all of the needs of their community? In fact, evidence shows that they will be less understanding of that. GPs are not trained in needs-based analysis or in health economic analysis and they are certainly not trained in public policy, as are many of the managers who tried to do that sort of equitable distribution in balancing out the needs across the community.

Considering how the GP pathfinder consortia are shaping up right now—varying from 16,000 patients in one part of the country to 600,000 patients in another—I think we all realise that there is a huge amount of work to be done to determine what the optimal size of GP consortia is, so that they will have the requisite understanding and scale and capacity to respond financially and intellectually to local needs. That work has not yet been done, however, so we Opposition Members are very concerned about greater inequalities being a direct consequence of the Bill. That is why the amendment matters. It reflects the fact that the Government are basically taking a leap of faith, and buying into the notion that the market will deliver better outcomes. We do not believe that that is the case, which is why the amendment would place a greater duty on the Secretary of State to safeguard against those inequalities. For that reason, I will certainly support the amendment and I urge Members of all parties to do that same.

Mr Burns: This has been a relatively long debate in the context of the Committee. A variety of points were made, some of which were more interesting and relevant than others.

I begin by reminding all Committee members that this is the first NHS Act in history—with that I include the original 1946 Act, and all the Acts of the 1950s, 1960s, 1970s, 1980s and 1990s, and even those under the previous Government between 1997 and 2010—to include an equality duty for the health service. This is the first time that such a duty has been put in primary legislation, and that should be put in context because it certainly was not done by the Labour party, which had opportunities to do so in 2009, 2006, 2002 and 2003. Given that some Labour Members used their speeches to portray themselves as the only ones with a monopoly on caring and a concern for inequality, it is slightly staggering that it is a Conservative-Liberal Democrat coalition Government who are actually doing something, and instead of just talking the talk, walking the walk—[Interruption.] I am glad that the hon. Member for Leicester West is amused by that because she, perhaps more than her hon. Friends, understands the veracity of that statement.

Liz Kendall: The right hon. Gentleman mistakes my generally pleasant demeanour for amusement. I am not amused by many of the changes that the Bill will bring in, and I am proud of the previous Labour Government’s achievements on tackling inequalities.

The Minister of State, Department of Health, the hon. Member for Sutton and Cheam, who is not in the room, denied that there had been a reduction in teenage
Mr Burns: I am sorry; I have made a mistake. I was trying to be complimentary and friendly to the hon. Lady, but I have learned from my mistake and I promise not to do it again.

I appreciate that we are debating the amendment and clause stand part, so I shall start by considering the clause and answering some of the questions that have arisen in the debate before I discuss the amendment.

The clause creates a new duty on the Secretary of State to reduce inequalities in the benefits obtained by different people from the health service. My hon. Friends and I have not necessarily had that point if they had listened simply to Labour Members, but fortunately we had the balancing sensibilities of my hon. Friend the Member for Stourbridge and the hon. Member for Stockport—[HON. MEMBERS: “Southport.”] Southport; I will get it right eventually.

That duty underlines our commitment to fairness across the health service. As I said in my introductory comments, it will be the first time that the Secretary of State is placed under a specific legal duty to reduce inequalities in the NHS.

Emily Thornberry: Given that the Minister has just said that the clause, as he understands it, gives a specific duty to the Secretary of State to reduce inequalities, will he therefore support my amendment 6, which would do exactly that? Amendment 6 would delete, “must have regard to the need to reduce” inequalities, and would simply introduce a duty.

The Chair: Order. The hon. Lady is trespassing on the next amendment.

Mr Burns: Thank you, Mr Hood. I am grateful for your guidance, because I was going to make the very same point that I will not be distracted by the next amendment because we will no doubt have a full debate on that in which we can discuss the merits of what the hon. Lady says.

Derek Twigg: I understand the political point that the Minister is making about this being the first time that such a provision has been put into a Bill. The Government would deserve credit for that if the Bill contributed in any way to what they intend. This has been our argument throughout. The fact is that the words are fine, but the actions will not follow.

Mr Burns: If I study logically what the shadow Minister says, that cannot be right at this point. The Bill has not yet come into effect because it has not even been given Royal Assent. At the moment, we and the NHS continue to reduce health inequalities in the same way that the previous Government tried to do.

The Secretary of State will be under a duty to have regard to the need to reduce inequalities in relation to the benefits that individuals can obtain from the health service. That includes access to health services and the outcomes achieved in relation to NHS services and public health. The need to reduce inequalities will be embedded throughout the system. The NHS commissioning board and the commissioning consortia will all be subject to corresponding duties.

3.45 pm

I want to draw the Committee’s attention to the measures that will apply throughout the health service at different levels to make sure that it focuses on driving down inequalities and improving the system for all people.

Grahame M. Morris: Given the Minister’s commitment to addressing inequalities in health and access to services, does he support the idea set out in the amendment of an annual report to Parliament? Surely that would improve accountability, and I do not understand how that runs counter to the tenor of his argument.

Mr Burns: I was going to deal with that when I spoke about the specific amendment, but I will deal with that now. I was slightly taken aback by the intervention in one respect because we had a lengthy debate on Tuesday about holding the Secretary of State to account. He has to produce an annual report that will be laid before Parliament. That report will obviously cover the question of health inequalities, so we already have that among the responsibilities that the Secretary of State must fulfil when he is being held to account for the NHS. I hope that the hon. Gentleman is heartened that what he wants is going to happen, even if there will not be a stand-alone annual report. Quite frankly, I do not think we need an annual report on every individual aspect of the health service. It will be far better, far more comprehensive and far easier to understand if we have one document rather than a whole load of separate documents.

Emily Thornberry: Will the Minister give way?

Mr Burns: No.

Emily Thornberry: It is my amendment.

Mr Burns: As I said, I am dealing with stand part first and then I will deal with the hon. Lady’s amendment, when she can talk to me to her heart’s content.

I want to deal with some specific questions raised by members of the Committee. The first one—this will please the hon. Lady—is one of her questions: why do we not spell out every source of inequality in the Bill, as she proposes? There is a practical point. If we try to be comprehensive, there is always a risk that certain groups will be left out, and I do not think that the hon. Lady would want that to happen, particularly as those groups would then be set out in an Act and if we wanted to add, remove, change or modify them, we would need primary legislation to do so, which would not be a sensible way to proceed.

Secondly, the public sector equality duty deals with inequality based on the protected characteristics listed in the Act. The duty in the Bill would cover health inequalities that arise for any reason, whether we can...
think of them now or following the passing of the Bill. That should be welcomed by the Opposition, because that such an all-embracing approach can help in the future by catching situations that may develop and need addressing.

The hon. Lady's next question was: will consortia budgets be blown, as she put it, by lots of patients with complex needs? I hope that she will listen carefully to my answer simply because she rightly expressed a concern, but made a few statements about the situation that bore little relation to what the Bill does. First, GPs cannot turn patients away because they have a complex or particular medical condition. There are professional regulations against that now, and that will not change. Secondly, the allocations to consortia will need to include risk-based calculations that factor in prevalence of disease and other demographic factors. Thirdly, the Bill makes provision for consortia to establish a risk pool, so that can help in year. Finally, the NHS commissioning board can intervene if a consortium is at significant risk of failure. Its powers range from being able to request information to the dissolution or merger of consortia, or asking another accountable officer to take over. I hope that that reassures the hon. Lady.

The hon. Member for Leicester West said that consortia have duties only towards patients who are registered with practices. That is not correct under the terms of the Bill. GP consortia will be responsible for both their registered and unregistered populations in a determined area—that is in clause 9, if she would like to look it up. The board has a duty to ensure that the whole of England is covered by consortia, so no population will be left without being covered in one way or another by GP consortia.

The hon. Member for Easington asked why the Secretary of State’s duty in relation to inequalities is different from that of the board in proposed new section 13F of the National Health Service Act 2006, as detailed in clause 19. Amendment 5 would make the two duties similar. The reason why the Secretary of State’s inequality duty is drafted differently from those of the board and consortia is because of the Secretary of State’s duties on public health. The duties on the board and consortia—we will come to those in future sittings, and I do not want to go too far down that road so that I do not fall foul of the rules—are drafted in terms of accessing health services and outcomes achieved by health services. The Secretary of State has duties on to public health that would not necessarily be caught by that wording, for example through information or education campaigns. I hope that that satisfies the hon. Gentleman.

I return to a question that a number of Opposition Members raised about whether the proposals for reform will cause less equitable access to, and outcomes from, care. I strenuously reject that notion because that is not the outcome of anything that we are proposing in the Bill. In fact, the exact opposite is true, because we are proposing a duty on the Secretary of State, the national commissioning board and the GP commissioning consortia to have regard to the need to reduce health inequalities. We are enshrining those duties in law for the first time.

**Dan Byles:** Does the Minister share my bewilderment at the comment that the hon. Member for Islington South and Finsbury that somehow patient choice is a threat to quality of services? I found that, and the apparent rolling back of the Labour party from the patient choice agenda, bewildering.

**Mr Burns:** My hon. Friend makes a perspicacious point, because I too was confused by that. That is why I was tempted at the time to intervene on the hon. Lady to remind her of the manifesto commitment of the Labour party at the previous general election—on which she fought—about choice. I did not get a response to my question, because her manifesto commitments seem to go completely against the general drift of the point that she was making, which my hon. Friend has picked up so perspicaciously.

I could go through a whole list of different checks and balances in the Bill that reinforce the duties and the need to deliver on reducing and minimising inequalities. For the sake of brevity and interest, I will not, because I know that hon. Members, who have expressed such an interest in the subject, will be prepared to look it up in the Bill and to inform themselves more to allay some of the misguided and incorrect fears that we have heard from Opposition Members.

The amendment would create an aspirational duty, against which the Secretary of State could not be held to account, which seems, however well intentioned the amendment, to be a perverse consequence of what the hon. Member for Islington South and Finsbury is seeking to do. If challenged, how could the Secretary of State demonstrate that his actions had actually reduced health inequalities? He is, however, able to show that he has had regard to the need to reduce inequalities by demonstrating, for example, that he has factored the relevant issues into his thinking when exercising functions. The duty to have regard to the need to reduce inequalities, as currently drafted, gives the Secretary of State a duty, which he is fully able to discharge and for which he can, therefore, truly be held to account.

Secondly, as we have discussed, the term “have regard to” is an established phrase that does not in any way imply a weak commitment. I will not repeat the legal comments that I read out to the Committee earlier, because they are equally relevant here.

The amendment also seeks to specify what is meant by “the benefits that” individuals “can obtain from the health service” and the characteristics of inequality that the Secretary of State should endeavour to address. The duty, as currently drafted, has been kept purposefully broad to capture all types of inequality that may affect individuals, including those listed in the amendment. Personally, I would have thought that, in the light of that information, hon. Members would welcome the way in which we have drafted the Bill, rather than the way that the Opposition have drafted their amendment. It would be a mistake to limit the scope to specific areas. Furthermore, the issues in the amendment are already covered, in large part, by duties under the Equality Act 2010, which apply to all public bodies, including the Secretary of State. To reproduce them in the duty would simply replicate existing legislation, which, I must say, in the context of those comments, seems unnecessary.

The coalition Government are fully committed to the Equality Act 2010, and we have already started to implement it. The equality duty will come into force on 6 April and the ban on age discrimination from 2012. We have been clear that the 2010 Act applies to all
[Mr Simon Burns] existing and all proposed health bodies, as well as providers of NHS services. I ask the hon. Lady to think again and to withdraw her amendment. If she is not prepared to do that, I invite my hon. Friends to join me in opposing it if it is pressed to a division.

Emily Thornberry: I will be brief as I am mindful of the time. I have made notes and listened carefully to an interesting debate, which has had thoughtful contributions from both sides of the Committee that have shown the huge importance of the issue. If hon. Members will forgive me, I will not go through the notes that I have made in relation to anything that they have specifically said.

It has been suggested that, on this side of the Committee, there is some churlishness about us not recognising that the equality duty is in the Bill. If we have given that impression, I apologise. The point that we are trying to make is not that there is no nod towards equality in the Bill, but that it is so little and that it is so pathetic. In fact, in many ways, the Minister has exposed himself and shown the clause to be the limp thing that it is. He said that the amendment gave the Secretary of Secretary a million aspirational duties that he could not fulfil. Is that a criticism of the amendment? The amendment would replace what is stated in the Bill, that “the Secretary of State must have regard to the need to reduce inequalities”, with the idea that he has a duty to do something about it. There is a big difference. Instead of a nod to equalities and playing at the idea of taking them seriously, the idea that he has a duty to do something about it. The Bill, as I have said, will go backwards regarding equality in the NHS, and it is important that there is a clear duty. There is an element of churlishness in that the title of the clause states: “The Secretary of State’s duty as to reducing inequalities”. All we want the Government to do is to make clear exactly what that duty is and spell it out so that all of us are clear. We must not play with an issue as important as equality.

4 pm Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 13.

Division No. 9]

AYES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

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
Soubry, Anna
Sturdy, Julian

Emily Thornberry: I beg to move amendment 6, in clause 3, page 3, line 5, leave out ‘must have regard to the need’ and insert ‘has a duty’.

The Chair: With this it will be convenient to discuss the following:

Amendment 9, in clause 3, page 3, line 5, leave out ‘between the people of England’.

Amendment 7, in clause 3, page 3, line 6, after ‘benefits’, insert ‘and quality of care’.

Amendment 14, in clause 3, page 3, line 7, at end insert— ‘The duty of the Secretary of State under this section shall include upholding the provisions of the Equality Act 2010 and the NHS Constitution as defined in Section 1 of the Health Act 2009, and ensuring that these provisions apply to—

(a) the National Health Service Commissioning Board;
(b) commissioning consortia;
(c) local authorities (as respects their public health functions);
(d) Health and Wellbeing Boards; and
(e) all providers of health care services for the purposes of the NHS.’.

Emily Thornberry: I will be brief as many of the matters were covered in the stand part debate. The reason why we have tabled the amendment is self-evident, and we have already debated it. We tabled amendment 9 because it would be helpful if the Bill clarified the phrase “people of England” to confirm that it will cover all those present in England who are entitled to NHS care. That is compatible with non-discrimination legislation. I have heard what the Minister said this afternoon regarding the entire population being within a GP consortium, but there is concern that the Bill is insufficiently clear on GPs’ responsibility for the entire population, and that we will be left with a doily approach. For example, there is a concern that the most vulnerable, such as homeless people with mental problems who are not on a GPs’ list, will not be seen as a responsibility of GPs. It is important that we receive reassurance on that.

Mr Burns: I have already explained when we debated the previous amendment that that will not be the case. The hon. Lady can have the assurance.

Emily Thornberry: I am grateful to the Minister for that reassurance. He will remember the evidence of Dr Gerada, who raised that issue. /Interuption./ The Minister sighs and rolls his eyes, but Dr Gerada is an important individual in the context of the NHS. Given that she represents GPs, it is important that her organisation understands what the clause really means. I am grateful to the Minister, and I do not want to be churlish.

Amendment 7 has also been covered already, so I now move to amendment 14. The reference to the NHS constitution is of great importance because its first principle is that there should be equality. I do not want to repeat arguments that have already been made, but it is fundamentally important that the Bill states that the Secretary of State has direct responsibility to ensure that all the listed bodies act in a proper and equal way.
The Equality and Human Rights Commission has expressed concern. I do not know whether the Minister remembers reading its Second Reading briefing, but it raised an important point. The equality duty was created by the Equality Act 2010 and comes into force in 2011.

4.7 pm

Sitting suspended for a Division in the House.

4.24 pm

On resuming—

Emily Thornberry: Before the Division, I was referring to the equality duty as created under the Equality Act 2010 and the concerns of the EHRC. A Second Reading briefing stated:

“The Commission is concerned that with proposed changes to commissioning, there is a risk that services may not be subject to the fundamental protections contained in the new Equality Duty... The Commission would advise that the ways in which equality and human rights legislation will apply to commissioning, service delivery, regulation and inspection of the National Health Service should be made more explicit, either on the face of the legislation or clear statements of commitment.”

I pray that in aid particularly of perhaps the most important part of our amendment that would place a specific duty on all providers of health care services for NHS purposes, so that private providers are also under no misunderstanding that they are subject to the Equality Act and the equality duty.

The Minister spoke about annual reports to Parliament by the Secretary of State, and I hope that that annual report will make specific, detailed reference to the Department’s progress in reducing inequalities. Given that that is included, we will not press the relevant amendment.

Mr Burns: I am grateful for a further opportunity to deal with some of those issues, because they overlap with our earlier debates. I have spoken about the wider principles of the clause, so I will focus more directly on the amendments in this group.

Amendment 6 seeks to turn the duty to “have regard to the need” to reduce health inequalities into having a duty actually to reduce them. I have outlined two reasons why I believe that amendment 5 is unnecessary. In summary, the amendment would create an aspirational duty, as I have said, against which the Secretary of State could not be held to account. Furthermore, the term “have regard to” is an established phrase, as I mentioned when I read out the legal quote explaining that. I will not test the Committee’s patience by reading it out again; I will take it as read. I also remind the Committee that the term is used in relation to the NHS constitution in legislation enacted by the previous Government. It is not as though we are doing something completely out of the blue and new. There is a precedent, and if it reassures Labour Members, that precedent was set by their Government, so, from their point of view, it must be right.

Amendment 7 would add a reference to reducing inequalities in the quality of care. That is unnecessary, however, because quality is implicit within the more general term, “benefits”. The inequality duty in clause 3 is deliberately drafted widely, because it applies not only to health services, but to the Secretary of State’s public health duties, which we briefly alluded to earlier. When we come to discuss the inequalities duties on the NHS commissioning board and consortia, hon. Members will see that they refer to reducing inequalities in the outcomes achieved by the provision of health services, which I believe captures the point that the hon. Lady seeks to make with amendment 7.

Amendment 14 would impose a duty on the Secretary of State to uphold the provisions of the Equality Act and the NHS constitution. Furthermore, it seeks to impose a further duty on the Secretary of State to ensure that the provisions apply to certain key bodies in the health system. The Secretary of State and, indeed, all the bodies that are listed in the amendment are already subject to the provisions under that Act. Similarly, as I have mentioned, a set of legal requirements already ensures that all NHS bodies and providers of NHS services must have regard to the NHS constitution. Therefore, such legislation is already in place and, to my mind, the amendment is unnecessary.

The hon. Lady has kindly indicated that she understands that the amendment relating to the annual report is already covered by the overall annual report that the Secretary of State presents to Parliament on the NHS. If I understood the hon. Lady correctly, she will not press the relevant amendment to a vote. I urge the Opposition that it is not necessary to press the amendment to a vote, in light of my comments and explanations, which I hope that they will consider, but if they do press it to a vote, I invite my hon. Friends to join me in opposing them.

Emily Thornberry: I do wish to press the amendment to a vote.

Question put, That the amendment be made.

Division No. 10]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Smith, Owen

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Bystow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot

AYES

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

NOES

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Souby, Anna
Sturdy, Julian

Question accordingly negatived.

Ordered, That further consideration be now adjourned.

(Stephen Crabb.)

4.32 pm

Adjourned till Tuesday 1 March at half-past Ten o’clock.