CONTENTS

Written evidence reported to the House.
Clauses 3 to 5 agreed to.
Schedule 1 under consideration when the Committee adjourned till this day at Four o’clock.
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

No proofs can be supplied. Corrigenda slips may be published with Bound Volume editions. Corrigenda that Members suggest should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons, not later than

Saturday 5 March 2011

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

© Parliamentary Copyright House of Commons 2011
This publication may be reproduced under the terms of the Parliamentary Click-Use Licence, available online through The National Archives website at www.nationalarchives.gov.uk/information-management/our-services/parliamentary-licence-information.htm
Enquiries to The National Archives, Kew, Richmond, Surrey TW9 4DU;
e-mail: psi@nationalarchives.gsi.gov.uk
The Committee consisted of the following Members:

**Chairs:** † Mr Jim Hood, Mr Mike Hancock

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 1 March 2011

[Mr Jim Hood in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 48 Medical Schools Council
HS 49 Children’s Society
HS 50 Medical Defence Union
HS 51 Diabetes UK
HS 52 Health Professions Council
HS 53 Specialised Healthcare Alliance
HS 54 North West Scrutiny Support Officers’ Network
HS 55 Parkinson’s UK, the Motor Neurone Disease Association, the Multiple Sclerosis Society, Epilepsy Action, the PSP Association, Sue Ryder Care, the UK Acquired Brain Injury Forum and the Neurological Alliance
HS 56 Frances Crook
HS 57 Dr Leonard Fagin
HS 58 Royal College for Paediatrics and Child Health
HS 59 Association of British Insurers
HS 60 The Stroke Association
HS 61 Federation of Specialist Hospitals
HS 62 The Children’s Trust, Tadworth
HS 63 National Autistic Society
HS 64 Breast Cancer Campaign

10.30 am

Clause 3 ordered to stand part of the Bill.

Clause 4

The Secretary of State’s duty as to promoting autonomy

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 15, in clause 4, page 3, line 10, leave out ‘autonomy’ and insert ‘collaboration and integration’.

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

Amendment 16, in clause 4, page 3, line 15, leave out from ‘purposes’ to ‘and’ in line 17 and insert ‘must cooperate with other commissioners and providers of health services and local authorities, with respect to their duties under section 179 of this Act.’.

Amendment 122, in clause 19, page 17, line 43, after ‘with’, insert ‘other consortia and’.

Amendment 123, in clause 19, page 17, line 44, at end insert—

‘(1A) In exercising its function of arranging for the provision of services for the purposes of the health service in England, the Board must act with a view to encouraging providers of health services to cooperate with other providers of health services for the purposes of the NHS, commissioning consortia, and local authorities.

(1B) Where the duty in this section conflicts with the duty to promote autonomy as specified in section 13E, the duty in this section shall be the primary duty.

(1C) Where the Board, its members, members of its committees or sub-committees, or its employees, are acting in accordance with this duty, they shall not be regarded as preventing, distorting or restricting competition for the purposes of section 2(1) of the Competition Act 1998 or Article 101 of the Treaty on the Functioning of the European Union.

(1D) If the Board finds that a licensed provider of health services for the purposes of the NHS is failing in its duty to cooperate with other providers of health services for the purposes of the NHS, commissioning consortia, local authorities and the Board, it shall refer the provider to Monitor under its powers under section 82.’.

Amendment 124, in clause 22, page 30, line 31, at end insert—

14NA Duties as to integration and collaboration

(1) Each commissioning consortium must, in the exercise of its functions, cooperate with the NHS Board, other commissioning consortia and local authorities.

(2) In arranging for the provision of services, each commissioning consortium must act with a view to encouraging providers of health services to cooperate with other providers of health services, commissioning consortia, local authorities and the Board.’.

Amendment 125, in clause 54, page 64, line 3, at end insert—

‘(ca) the need for commissioners of health care services to cooperate with one another with respect to section 72 of the National Health Service Act 2006 and with providers of health services for the purposes of the NHS to ensure that providers of health services cooperate with other providers of health care services, commissioning consortia, local authorities and the National Health Service Commissioning Board.’.

Amendment 126, in clause 82, page 80, line 32, at end insert—

‘(2) If a provider of health services for the purposes of the NHS is referred by the National Health Service Commissioning Board with respect to subsection (1D) of section 13J of the National Health Service Act 2006, Monitor shall investigate with respect to the provider’s licence.’.

Amendment 127, in clause 90, page 84, line 26, at end insert—

‘(ea) requiring the licence holder to do, or not to do, specified things (or to do, or not to do, specified things in a specified manner) in order to promote cooperation in the provision of health care services for the purposes of the NHS,”.

Amendment 128, in clause 179, page 152, line 29, at end insert—

‘(1A) A Health and Wellbeing Board must, for the purposes of advancing the health and wellbeing of the people in its area, ensure that commissioners and providers of health care services...
for the purposes of the NHS cooperate with other providers of health care services, commissioning consortia, local authorities and the National Health Service Commissioning Board.

(1B) If a Health and Wellbeing Board finds that a licensed provider of health services for the purposes of the NHS is failing in its duty to cooperate with other providers of health services for the purposes of the NHS, commissioning consortia, local authorities and the National Health Service Commissioning Board, it shall refer the matter to Monitor for consideration.

Emily Thornberry: The amendments go to the heart of the sort of national health service that we want to see. They are important. Nevertheless, I hope to deal with them quickly today—certainly more quickly than I dealt with the last clause. I thought it fair to tell the Committee that, although I do not mean to say that the issues are not important.

The amendments reflect the need for collaboration and co-operation in the NHS, because we want to achieve that as a holy grail. Everyone agrees that we need integrated services. Co-operation and collaboration, not autonomy and competition, should be at the heart of the NHS and of the Bill. We need to make it clear that services that work together and collaborate are desirable and will not be threatened by competition law.

The Secretary of State's duty to promote autonomy, as the Bill currently stands, is bizarre when set beside such important duties as improving services and reducing inequalities. Even more extraordinary is the fact that the apparent duty of the Secretary of State is not to the NHS as a whole, but is effectively to reduce the level of co-ordination. If we want integrated services, the ideal circumstances would be ones where there is an atmosphere of mutual trust, where there is not huge reorganisation and where services do not feel threatened by a reduction in resources. These hardly seem to be ideal circumstances, even at the best of times, for integrated services.

The huge reorganisation that the Bill introduces, at the same time as the efficiency savings in the NHS, threatens to create total chaos. We have heard from policy wonks on the Government Benches that that sort of chaos can be creative, but we do not need creative chaos in the NHS. Services need to co-operate and collaborate ever more to achieve integrated services. Will the Minister tell us how the Bill will make increased integration and co-operation more likely?

What people with long-term conditions such as Parkinson's or cancer are concerned about is how their whole treatment pathway will be planned, and how commissioners—either the NHS commissioning board or the consortia—will ensure that there is understanding and knowledge about their condition at every stage of their care. During the oral evidence sessions, we heard concerns from many organisations about the fragmentation that might result from the reforms, and I crave the Committee's indulgence as I quote a few of the witnesses.

Dr Meldrum of the BMA—[Interruption. I see the Minister rolling his eyes. Doctors are prayed in aid when it comes to their being reliable and wise, and given twice the Defence budget, but when they criticise the Government, they are cast aside.

Emily Thornberry: Dr Meldrum said:

"I think the other risk that we see is the possibility of destabilisation and fragmentation of services at a time when you need integration and co-operation."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 19, Q41.]

Dr Meldrum of the BMA—[Interruption. I see the Minister rolling his eyes. Doctors are prayed in aid when it comes to their being reliable and wise, and given twice the Defence budget, but when they criticise the Government, they are cast aside.

Emily Thornberry: Dr Meldrum said:

"However, we have a number of concerns about the Bill. One is about the duplication of care and fragmentation".

She went on to say:

"We are also concerned about the split between choice and competition—we would rather see collaboration, co-operation, shared care and integration. Those are—briefly—some of our concerns."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 43, Q94.]

They are—briefly—the concerns of many.

Finally, Anwen Jones, from Target Ovarian Cancer, said:

"In the past 10 years in cancer, with the reorganisation of services, we have seen significant progress in outcomes as a result of that specialisation. We do not want to see fragmentation happening as a result of considerations other than clinical need. Concern about that is real, and we want to see how it will be addressed. —[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 130, Q298.]

In the background of our debate, there is without doubt real concern about fragmentation of services and how we will increase integration; to see at the beginning of the Bill a duty being placed on the Secretary of State to increase autonomy simply exacerbates that concern.

Ultimately, the amendments are about placing what is needed for good, clinical care—a collaborative integrated system in which every NHS body is focused on the needs of the patient in particular and the public in general—over the Government's dogmatic belief that autonomy, competition and the free market are always best in all circumstances.

Mr Burns: The amendments deal with co-operation and integration throughout the health and social care system. Clearly, those are important themes. Although I shall talk about each amendment individually, I will take the opportunity to refer to our overall approach, to help the hon. Lady. The Government recognise and are an active advocate of the benefits of integration, including better outcomes for patients and a better patient experience. We have made it clear that we intend to create a health and social care system that achieves better outcomes and is designed around individuals rather than institutions.

We are absolutely committed to the principle of autonomy, and clause 4 puts that principle at the heart of the NHS. It is about eliminating the political micro-management that constrains the freedom of hard-working professionals to focus on what matters most to us all: improving outcomes for patients. If we want to improve
outcomes in the NHS, we need to empower our front-line professionals. The Bill confers functions directly on the bodies most capable of discharging them. The principle is about giving those bodies the freedom to exercise their functions, so long as that is consistent with the interests of the health service and patients.

I can sympathise with the intention of the amendments, which seek to emphasise the role of integration and collaboration. However, what they propose seems to be based on two assumptions with which I cannot agree, the first of which is that somehow integration can happen only at the expense of autonomy. The partnerships necessary to support integrated services need to be created at a local level by building effective relationships between local bodies. The Secretary of State cannot do that for them, and it is more likely to happen if bodies are not constantly looking up to Whitehall.

Amendments 15, 16 and 119 are all based on the assumption that autonomy and collaboration cannot co-exist happily together. In fact, they are not mutually exclusive; it is not a case of either/or. There should be no conflict between autonomy and co-operation when both are consistent with the interests of the health service. The Government agree that, where appropriate, organisations should co-operate to deliver the best possible services for patients. That is why the Bill sets out explicit duties for bodies to co-operate with one another. For example, clause 266 places key national bodies under a duty to co-operate. Health and well-being boards will have a role in promoting integrated working and shared commissioning of health, social care and public health services to meet better the needs of individuals and families using the services.

The second assumption is that the Bill weakens the legislative framework for collaboration and integration. It does nothing of the sort—it strengthens the framework in several ways that I shall explain in the context of the amendments. Amendment 120 would do two things. It would replace the board’s autonomy duty with a duty of co-operation and it makes specific reference to the new duty under clause 179—health and well-being boards will promote integrated working and shared commissioning of health, social care and public health services to meet better the needs of individual families using the services.

The second assumption is that the Bill weakens the legislative framework for collaboration and integration. It does nothing of the sort—it strengthens the framework in several ways that I shall explain in the context of the amendments. Amendment 120 would do two things. It would replace the board’s autonomy duty with a duty of co-operation and it makes specific reference to the new duty under clause 179—health and well-being boards will promote integrated working and shared commissioning of health, social care and public health services to meet better the needs of individuals and families using the services.

I have already explained that we are committed to empowering professionals to exercise their functions as they see fit. That is why the duty is important.

Furthermore, I have explained why I believe that autonomy and co-operation are not mutually exclusive. Given the other provisions in the Bill, it would be unnecessary to introduce an additional duty of co-operation in clause 19. However, the NHS commissioning board will have an important influence over consortia behaviours, through its functions of developing commissioning guidance for the consortia and of setting the indicators in the commissioning outcomes framework against which the performance of consortia will be assessed, and through practical tools such as the development of tariffs. That is why clause 19 places an explicit duty on the board, under proposed new section 13J, to encourage consortia to work closely with local authorities.

Amendment 122 would add a requirement to encourage consortia to work closely with each other. The purpose of proposed new section 13J is to promote close collaboration between consortia and local authorities in the arrangement of integrated services, such as can be achieved under section 75 of the National Health Service Act 2006. In addition, the duty for NHS bodies to co-operate—under section 72 of the Act—will, of course, also apply between GP consortia.

Under clause 179, the Bill also provides that a health and well-being board must encourage integrated working. If two or more consortia are members of one health and well-being board, they will need to comply with the duty to work with each other in an integrated manner. That is in addition to the existing provisions in the Bill, which promote collaborative working between consortia. The amendment is therefore unnecessary.

Amendment 123 seeks to develop the general duty on the NHS commissioning board in clause 19, under proposed new section 13J, to encourage providers of services to collaborate with each other for the purposes of the NHS, and with consortia and local authorities.

Amendment 128 would create a similar duty for local health and well-being boards. I assume that the hon. Members who tabled the amendments have done so to constrain the actions of providers to act competitively where, in their view, it might be in the best interests of the NHS for them to act collaboratively, with fellow providers, commissioning consortia and local authorities.

The role of Monitor, as economic regulator, will be to ensure that the social market for provision of NHS services operates in the public interest. Monitor will do that by promoting patient choice and competition on quality, where appropriate, by setting or regulating prices and by supporting the continuity of services. Monitor will promote patient choice and competition for services on a fair playing field. It will have powers to address restrictions on competition and quality if they act against the public interest.

Under amendment 124, the Opposition again seek to add duplicate powers into the Bill and the 2006 Act. The amendment to clause 22 would impose two linked but different duties on commissioning consortia. I will address them in turn. The amendment’s proposed new section 14NA(1) seeks to introduce a duty for a consortium to co-operate with the board, other consortia and local authorities. However, the provision has already been made elsewhere. Paragraph 129(3) of schedule 4 amends section 275 of the 2006 Act to provide for consortia and the NHS commissioning board to be NHS bodies for the purposes of the Act, ensuring that the board and the consortia are covered by the existing duties of co-operation, which already apply to NHS trusts and NHS foundation trusts. In section 72 of the 2006 Act, NHS bodies have a duty “to co-operate with each other in exercising their functions.” Additionally, under section 82 of the same Act, they have a duty to co-operate with local authorities “to secure and advance the health and welfare of the people of England and Wales.” Therefore, the proposed new sub-paragraph (1) in amendment 124 is superfluous.

Amendment 124’s proposed new section 14NA(2) would impose a duty on consortia to commission services “with a view to encouraging providers of health services to cooperate with other providers of health services, commissioning consortia, local authorities and the Board.”
We have already explored how NHS bodies, which include NHS trusts and foundation trusts, have a legal duty to co-operate among themselves and with local authorities. I am confident that the Opposition will not press the amendments when they appreciate that there are already clear and unambiguous duties for NHS bodies to co-operate, which must be carried out as a matter of law rather than as a matter of encouragement.

Amendments 125 to 127 aim to place new requirements on Monitor to promote co-operation. They are linked to amendments 123 and 128, which would place new duties on the NHS commissioning board and local health and well-being boards to refer providers to Monitor if they fail to co-operate. I understand the aim behind the amendments, but they are misconceived. As I have mentioned, Monitor will have powers to ensure that competition works fairly and in the interests of patients. It is not necessary to invent a parallel set of functions for Monitor to oversee the extent to which providers co-operate with each other.

10.45 am

To conclude, there is no need to impose unnecessary new duties and burdensome regulation. Our provisions encourage commissioners and providers to work together in the interests of patients. All parts of the system, including all those who provide NHS-funded services, will be bound by a legal duty to have regard to the NHS constitution and the core principles that it enshrines, one of which is that

“The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.”

True co-operation is a matter of shared values and behaviour; it is not something to be measured and micro-managed through Government regulation. For those reasons, I ask the Opposition not to press the amendments, but if they decide to do so, I ask my hon. Friends to join me in opposing them.

**John Pugh** (Southport) (LD): I accept the Minister’s point that at times there may be no conflict between autonomy and collaboration—but sometimes there might be, as seems perfectly obvious. We seek to amend a small section of the 2006 Act, which states the Secretary of State’s duties. Under section 1(1) he must promote “the physical and mental health of the people of England” and encourage “the prevention, diagnosis and treatment of illness.” That is fine, but clause 4 adds to that description of the Secretary of State’s duties a provision that defines how he carries them out: with a view to encouraging autonomy.

I have two points about that. Some aspects of the requirement are blindingly obvious; we would hope that any Secretary of State would do them at any time. Under clause 4, he must ensure when he carries out those duties—promoting good health and so on—that “unnecessary burdens are not imposed” on any person or provider. We would hope that that is so obvious that it is not worth stating in legislation. We would not want the Secretary of State to go out of his way to add burdens to people who are trying to provide health care.

The clause also states that he must exercise his functions in a manner that allows maximum freedom and autonomy to those who are providing the services. In other words, he should not meddle unduly. Again, that strikes me as a blindingly obvious good point—one does not want to interfere with people when they go about their general business.

I therefore pose a question. Why are we specifically adding a provision to describe how a Secretary of State should discharge his functions? Why does that provision refer only to autonomy and not to all the other matters that we should mention? Why can we mention autonomy here and collaboration elsewhere? There is no obvious answer to that. The measure adds an inelegant characteristic to the existing legislation, which refers to what the Secretary of State does.

**Emily Thornberry:** I am listening carefully to the hon. Gentleman, because he is making an important and intelligent contribution. Is there an interpretation of the clause that hints at what is at the centre of the Bill? Essentially, if it were to be either collaboration or autonomy, autonomy would win—that is the difference that the Government will make to the NHS.

**John Pugh:** It seems an attempt via legislation to give a particular sort of emphasis rather than to do anything considerable. I perfectly accept the points made by the Ministers, but in terms of real effect, there are adequate later provisions that will ensure that autonomy and collaboration will be balanced out in the interests of the NHS. There is no difficulty in the effect of the legislation.

I ponder the purpose of proposed new section 1C. Either it is stating something so blindingly obvious that it is hardly worth stating, or it is going into the realms of how the Secretary of State will do what he is supposed to do and what he is said to do in section 1(1)(a) and (b) of the 2006 Act. Why specify only that particular characteristic of his behaviour in carrying out his duties as defined in (a) and (b)?

**Mr Burns:** I hope that the hon. Gentleman’s intervention will help to clarify the situation. As I said during my comments, we need and want the NHS to work collaboratively and together. The purpose and point of the autonomy is to reflect the changing situation of the position of the Secretary of State within the ambit of the NHS under the terms of the White Paper—that is, to stop the Secretary of State from having day-to-day powers to micro-manage and interfere in the day-to-day running of the NHS. That is why that is in this part of the Bill.

**John Pugh:** I do not dispute that that is the objective. The point I am making, which may be a very trivial and minor point in the wider scale of things, is that I question the placing of that particular function in the legislation.

The first clause of the 2006 Act basically defines the fundamental things that the NHS does. It should restrict itself to that. In my view, it should not be amended to go into detail about how the Secretary of State should do things. That should be done at a later stage, as it is in the Bill. We have taken autonomy and put it in one place, and taken collaboration and put it in another.
That makes the legislation read inelegantly. I suspect a deliberate inelegance is put in to emphasise a change in tone. I do not think legislation should be used to do that when there is no real consequence to doing it.

**Emily Thornberry:** This debate goes further than proposed new section 1C, because there is a string of amendments in which we have attempted to identify the importance of injecting more collaboration and integration of services into the Bill. That is why we have attempted to make this into a thematic debate about where the NHS should be and where we want it to be.

The fact is that, as the hon. Member for Southport has said, proposed new section 1C of the 2006 Act will be front and foremost in the Bill, but it should not be front and foremost in a national health service Bill. Autonomy is not what the national health service ought to be about. In such circumstances, we are not minded to withdraw the amendments.

Amendment 15 negatived.

**Emily Thornberry:** I beg to move amendment 11, in clause 4, page 3, line 15, after ‘purposes’, insert

‘has complete autonomy from direction from the Secretary of State, the NHS Commissioning Board or Monitor, and’.

Amendment 11 is a probing amendment. Having said what we think about autonomy and its place in the national health service, we will not be pressing the amendment to a vote today, but we wish to understand the extent to which the Minister intends autonomy to reign in the national health service.

The purpose of the amendment is to probe the meaning of “autonomy”. Will the Minister clarify when things are too autonomous? We all listened to the evidence given by David Nicholson on Tuesday 8 February. Is the Minister aware that it has caused a great deal of debate and there is some concern about what Dr. Nicholson said? Some have interpreted his evidence on NICE quality standards as meaning bringing in a lot more centralised control of GPs. It is understood that his evidence was effectively that NICE will be setting down guidelines on what quality commissioning looks like.

GP consortia would have to commission to those standards. Does that mean that GPs are going to be told by the board what they should commission and when and how? Is there a plan for NICE guidelines to be enforced on GP consortia by the board? If that is correct, I presume that the Minister agrees that that is a great increase in central control of GPs.

Does he intend to do that? If so, could he explain further? Perhaps GPs need to know about it as well. How, in any event, can that be consistent with autonomy?

**Mr Burns:** I fully appreciate that the purpose of the hon. Lady's amendment is to probe our intentions. I hope that my explanation will be helpful.

Amendment 11 seeks to strengthen the autonomy duty set out in clause 4. It is a curious amendment, given the other amendments that we have been discussing. If I have understood it correctly, the logic behind the hon. Lady's previous amendments 36, 37 and 39 was to strengthen the ability of national bodies to hold local organisations to account for improving quality. Amendment 5 would do the same for inequality under clause 3. However, amendment 11 is a direct contradiction of the thrust of those amendments, allowing local organisations to act with complete disregard for the actions of national bodies. The thrust of the amendment would mean that consortia could pay no attention to the commissioning board's commissioning guidance, which is based on National Institute for Health and Clinical Excellence quality standards, reducing the ability of the board to provide leadership on improving quality. I can only suggest that the hon. Lady has not considered the consistency of her arguments.

As I have set out previously, the principle is about maximising autonomy, but in the context of preserving the core values of the national health service. The NHS is a national tax-funded service, and it must be accountable to the Government of the day and to Parliament, so it is right that Ministers set strategic direction and national priorities. It is when political micro-management prevents hard-working professionals from focusing on high-quality care that we fail to deliver the best possible outcomes for patients.

The Bill will create national bodies with the appropriate skills and experience to ensure that the health service works in the best interests of patients. We want patients to be able to choose from a range of providers that are accredited to provide safe and high-quality care and treatment, and select the one that best meets their needs. It would be inappropriate to allow any body or individual complete freedom from proportionate checks and balances. For that reason, I urge hon. Members to resist the amendment, although I understand that the hon. Lady has said that she is not going to press it to a Division. I hope that that goes some way in explaining why we do not agree with the general tone and philosophy behind the amendment.

**Emily Thornberry:** The Minister has not addressed my question about Nicholson and whether NICE guidelines will be imposed on GP commissioners through the national commissioning board, which seemed to be the force of Nicholson's evidence. If I am wrong, will the Minister tell me? If I am right, GPs ought to know about it. The provision flies in the face of what the Minister has been saying about the autonomy that GPs will be given. It is important that we get clarification on the issue. I would be grateful if the Minister could tell me—I understand that he may be able to tell me today. I am happy to give way.

**Mr Burns:** It might be sensible if the hon. Lady concluded her comments, in case there was anything else she would like to ask me about.

**The Chair:** Order. I hope I am keeping up. I thought that the hon. Member for Islington South and Finsbury was summimg up her amendment.

**Mr Burns:** I shall intervene, then. As I said, the thrust of the amendment would mean that consortia would not have to pay attention to the commissioning board's commissioning guidance based on NICE quality standards, which would be ludicrous. To turn it round the other way, consortia must have regard to commissioning guidance
based on NICE quality standards, but there is no power of direction for the board to order consortia to follow, hence the autonomy.

11 am

Emily Thornberry: I am grateful to the right hon. Gentleman, but his response throws up more questions than it answers, and there are additional questions. For example, if the national commissioning board was hoping that GPs would abide by NICE guidance, and a GP commissioning consortium was not doing so, what would the board do about it? Would it simply scratch its head and say, “Oh well, never mind, it is autonomous, it should be allowed to do that”, or would it do something about it? That is the central and centralising question, and it will be asked time and time again. I respectfully suggest to the right hon. Gentleman that he must provide a better answer.

Mr Burns: Let me try again by repeating what I said so that the hon. Lady fully understands. Consortia must have regard to commissioning guidance drawn up based on NICE quality standards. That seems quite straightforward to me.

Emily Thornberry: That brings us back to discussions about the English language—the importance of law and using English in a way that English people understand, and what it means to have regard to NICE guidance as opposed to doing what NICE says if NICE gives guidance—[ Interruption. ] I am grateful for being prompted from behind with a much better word—to follow NICE guidance as opposed to having regard to it. I have a piece of paper, to which I may have regard, and then I may ignore it.

Dan Byles (North Warwickshire) (Con): Given that we are getting into semantics, what does the hon. Lady think the word “guidance” means as opposed to, for example, “instruction”?

Emily Thornberry: That is exactly the sort of point that we must be able to answer. We need to know, particularly in the context of autonomy, if these bodies are supposed to be autonomous and in some way able to make their own decisions about unnecessary burdens, how that sits comfortably—

Several hon. Members rose—

Emily Thornberry: If I may finish. How does that sit comfortably with the idea of following guidance? I do not understand.

Graeme M. Morris (Easington) (Lab): On autonomy, the Minister was at pains to point out in an intervention on the hon. Member for Southport the distinction between micro-managing the service, particularly in terms of GPs, and their having some autonomy. How would that apply in relation to the same principles over financial regulations and investment decisions? Would the Minister’s interpretation of micro-management as against autonomy be turned completely on its head?

Emily Thornberry: As I said, there are several questions on the clause.

Mr Burns: May I explain yet again to the hon. Lady and my hon. Friend the nature of a duty of having regard to something. A key way in which a duty to have regard to something that must be carried out is to assess the impact of a proposed decision on policy on that thing, particularly to identify any positive or negative potential impacts, and to seek to mitigate any negative ones. It may help the hon. Lady to know that it is a phrase that is often used to describe the duties of public bodies. For example, the NHS constitution, which was drawn up by the hon. Lady’s Government when they were last in power, is a good example of a document to which NHS bodies must have regard. [ Interruption. ]

Emily Thornberry: We are both being passed notes.

Mr Burns: The hon. Lady is not.

Emily Thornberry: I have a note, but I have no further clarity. I have asked and asked again, and have tried to approach the issue from several different angles.

Mr Kevin Barron (Rother Valley) (Lab): The amendment and the answers that my hon. Friend received from the Minister may not be the autonomy that people would expect from such a clause. Clearly, the chief executive’s evidence suggests that they will have to stick to the guidelines for commissioners and providers. I am not saying that that is a bad thing, because the difficulty of spreading best practice throughout the national health service is the quest in which people have been engaged for 60 years. It is potentially the most top-down thing that has ever been done by them.

Emily Thornberry: Indeed, some of the other evidence that we heard during the evidence sessions was that NICE guidance is, unfortunately, ignored too often by GPs throughout the country. If we are now entering a brave new world in which NICE guidance will be adhered to, perhaps that is to be welcomed, but GPs ought to be told.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): On the way in which NICE guidelines are interpreted at the moment, most hospitals will have regard to them in relation to, for example, a CT for a head injury. They must, however, use clinical discretion in certain cases, such as when alcohol is involved with a head injury or if older people and a particular area are involved. I do not see how the clause differs from the implementation of that provision. There is a basic framework of good practice in relation to which clinical judgment needs to be exercised. Does the hon. Lady not accept that that is what the clause says?

Emily Thornberry: I think that the issue continues to be a moot point. I am grateful for the assistance that the Minister has attempted to give us.

Owen Smith (Pontypridd) (Lab): The question asked by our right hon. Friend the Member for Rother Valley a moment ago revealed that the Minister is attempting to have his cake and eat it. He tells us that there is a new duty of autonomy, but in reality the same stricture that has hitherto applied to NHS doctors will still apply. Does my hon. Friend the Member for Islington South and Finsbury agree that this is really about fiscal and
Economic autonomy, and the alliance of this clause to those relating to competition? That is why the clause appears so early in the Bill—it is about fiscal autonomy.

Emily Thornberry: I respectfully agree with my hon. Friend and made that point—but not as elegantly—at the beginning of my contribution. I will not press the amendment to a vote. I am grateful for the time that the Committee has spent on it, and I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 17, in clause 4, page 3, leave out line 18.

The Chair: With this it will be convenient to discuss the following: amendment 12, in clause 4, page 3, line 18, at end insert—

(c) for the purposes of this Act, “unnecessary burdens” shall exclude any requirements to—

(i) ensure public involvement, consultation and accountability, or

(ii) publish data relating to performance or quality of services.

Amendment 121, in clause 19, page 17, leave out line 3.

Emily Thornberry: The amendments seek to address the question of how autonomy fits with accountability and local democracy. The clause states that there should be no unnecessary burdens, but what are those burdens? Is it an unnecessary burden to pay attention to what the public want, or to be accountable to, or scrutinised by, the public? If that is what we are talking about, it is a matter of grave concern. The amendments seek clarification, and amendment 12 in particular seeks to make sure that public involvement, accountability and openness are not regarded as unnecessary burdens. What does the Minister have in mind when he talks of burdens?

Paragraph C76 on page 83 of the Bill's impact assessment causes us concern. It states:

"To ensure their autonomy, both board and consortia remain solely responsible for their commissioning decisions, and neither are obligated to gain approval from local councils or health and wellbeing boards for their commissioning decisions."

That lets the cat out of the bag. Are we to take it from that that accountability is an unnecessary burden?

John Pugh: It is often a test of political policy to negate it and see what negation means—that will then tell us what the policy says. The clause proscribes unnecessary burdens and is, in my view, almost an unnecessary clause. I think we could put it in any piece of legislation at any time. It is no wonder that legislation keeps expanding in this place, because we insert statements that are completely vacuous. It is rather like inserting a clause that says, "The Secretary of State should not spend unnecessary money or go to sleep on the job."

Nobody in their right mind will advocate that we impose unnecessary burdens or make any sort of case for imposing such burdens, because they are—to put it bluntly—unnecessary. The clause as it stands does nothing. There is a purist point of view that says, "Why put clauses in that do absolutely nothing?"

Mr Burns: The amendments raise questions about the duties on the Secretary of State and the NHS commissioning board to avoid unnecessary burdens on bodies providing, commissioning or regulating health services. As I said earlier, the specific purpose of those duties is to set out the principle that, when considering whether to place requirements on the health service, the Secretary of State and the NHS commissioning board should always consider the impact of their actions on health service organisations and ensure that they are acting proportionately.

Amendments 17 and 121 seek to remove the requirement that the Secretary of State and the NHS commissioning board should avoid unnecessary burdens. In other words, they suggest that the Secretary of State and the board should be able to impose unnecessary burdens on the health service, thus recreating the problems of the past. We know that front-line services have been subject to unnecessary burdens and targets, which have distorted priorities and distracted professionals from focusing on what really matters—high-quality patient care and improved outcomes.

Mr Burns: I suspect that, in general, the hon. Gentleman is right. There is a philosophical difference between the Government and the Opposition as to what the future of the NHS should be. We believe that it should be liberated and freed from the day-to-day micromanagement and interference—

Several hon. Members rose—

Mr Burns: Let me finish answering the hon. Member for Southport. We believe that it should be liberated and freed from the day-to-day micro-management of Ministers, whether it be by imposing politically sensitive targets, distorted clinical decisions, whether it be by direct interference with individual providers or whether it be interference in the day-to-day operation of commissioners. That is the difference—that is the philosophy outlined in the Secretary of State’s White Paper last July, and that is what the legislation before us today is based on.

Grahame M. Morris: When Sir David Nicholson gave evidence to this Committee, concerns were raised about variations in the service. Government Members were nodding in agreement about the need to ensure best practice and to ensure that there were not regional or national variations. He said that that would be done through framework agreements to identify diabetes and so on—some 150. I think he said. We do not disagree with that approach, because we should have the highest possible standards, but if that is not micro-management, what is it?
Mr Burns: It is providing better quality health care and seeking to enhance outcomes, because those 150 or so standards will be established on a clinical basis through NICE. That is the way to do it, rather than through the interference or direction of the Secretary of State. I agree that those standards, we hope and expect, will enhance and improve patient care. That is a plus point and a way forward; it is not day-to-day micro-management by politicians. I am sorry that the hon. Gentleman cannot see it.

Owen Smith: Will the Minister give way on that very point?

11.15 am

Mr Burns: No, because if it is on the very point that the hon. Member for Easington made, I have just answered it, so there is nothing more to be said.

The principles that we advocate, and which underpin this legislation, underline the importance of setting out a clear principle in the Bill, so that we cannot return to the era of top-down politically motivated targets and direct interference by Ministers in the day-to-day operation of commissioners and the affairs of individual providers. Such behaviour stifles the NHS.

Amendment 12 would specify that certain functions should be excluded from the Secretary of State’s duty to avoid unnecessary burdens. The intention is one with which I can sympathise: to ensure that the clause does not have the unintended side effect of decreasing public involvement or the availability of quality information. I can reassure the hon. Member for Islington South and Finsbury that the clause would not have such an effect. Clause 4 is about the relationship between the Secretary of State and the health service. It does not enable organisations to sidestep their statutory duties. The Bill confers appropriate duties in relation to patient and public involvement, consultation and accountability on relevant bodies in the system, and we envisage that the NHS Information Centre will publish data relating to performance, or quality of services.

Furthermore, the Bill and the clause set out unprecedented levels of transparency in decision making and public reporting, such as the obligation to consult on the development of the mandate of the commissioning board and the duty to publish and lay before Parliament an annual report on the performance of the health service, as we have discussed in earlier amendments. That information revolution will help to ensure that high-quality information is accessible to all. I notice that the hon. Lady will not press the amendment to Division—it was, to all intents and purposes, a probing amendment—so I hope that that goes some way to reassure her, but I somehow doubt that it has.

Emily Thornberry: Some of what the right hon. Gentleman said is reassuring, but again it highlights how woolly the meaning is in that part of the clause that states “that unnecessary burdens are not imposed on any such person”.

That is entirely subjective. Presumably, what a Conservative Secretary of State for Health thinks is an unnecessary burden—particularly of the current complexion—as compared with a Labour Secretary of State, will be completely different. In those circumstances, that part of the legislation is unnecessary, as the hon. Member for Southport has pointed out, but I do not intend to press the matter to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question put forthwith (Standing Orders Nos. 68 and 89), That the clause stand part of the Bill.

The Committee divided: Ayes 12, Noes 10.

Division No. 11]

AYES

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

NOES

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

Question accordingly agreed to.

Clause 4 ordered to stand part of the Bill.

Clause 5

The NHS Commissioning Board

Liz Kendall (Leicester West) (Lab): I beg to move amendment 43, in clause 5, page 3, line 36, at end add—

‘(c) must lead in the reconfiguration of services for the areas over which it has commissioning responsibility, and

(d) have regard to the principles and values of the NHS Constitution.’.

Amendment 43 seeks to make two key points. First, the board, when discharging its duties, must lead the service reconfiguration for which it has responsibility for commissioning and, secondly, the board, when discharging its duties, must have “regard to the principles and values of the NHS Constitution.”

In the interests of making progress, I do not want to repeat in detail all the debates that the Committee has had about service reconfiguration. However, I want to remind members of the Committee—not that they need reminding, but for my own benefit—of some crucial points. First, we all know that major reconfigurations of services are absolutely vital for improving quality of care, which is not only about saving more lives but about increasing the number of people who can live lives that are free from serious disability. I am thinking of two key issues in that regard. The first is stroke care, and we have already said that there is an important issue about specialising services in some hospitals. However, an area that needs serious and rapid progress is trauma care. There is absolutely clear evidence that when trauma services are provided in more specialist centres they save lives. There are some very basic points to make. If someone experiences a major trauma in the evening, at night or at the weekend and they are sent to the wrong...
hospital, their chances of survival are far worse than if such an incident happens during the day and they go to a major trauma unit. In fact, when considering the quality of care for trauma services, there is an awful lot that we could learn from what happens to some of our troops abroad. In the NHS, we have not got to the standard of quality of care in trauma services that we need.

The problem with the Bill is that it is not clear where responsibility lies for major service reconfiguration. I know that the Government have said that GP commissioning consortia can either group together or that one of the partners can take the lead on service reconfigurations in their particular area. I remind Members of the evidence that we heard from Stephen Thornton of the Health Foundation, who said that all the research into lots of different experiences of giving GPs more control over commissioning shows that GPs are good at changing and developing community and primary care services, because those are the services they know about, but the evidence that they have successfully led large hospital reconfigurations is, at best, lacking. That point was also made by Nigel Edwards of the NHS Confederation.

There is a worry that GPs might not have the skills to carry out major reconfigurations of services quickly. Strategic health authorities have led many major service reconfigurations. I know that some members of the Committee feel that those reconfigurations have not been done as well as they might have been done, but I have already cited the example of stroke care in London, which was led by NHS London. That reconfiguration was very difficult and challenging, but it is already saving lives and improving patient outcomes. However, if SHAs go, who will lead major service reconfigurations?

Dr Poulter: The hon. Lady defends SHAs and, judging from her argument, she says that bigger is always better. However, if we have only regional centres, we will not develop key services in local district general hospitals that will save lives. A good example of that is in heart care with angioplasty intervention, which is the gold standard. However, because of this “bigger is better” approach, that standard has been lost in many DGHs. That standard is what we should be developing in DGHs. Does she accept that it is a good thing to develop key services in local district general hospitals, because those are the services they know about, but that the evidence that they have successfully led large hospital reconfigurations is, at best, lacking. That point was also made by Nigel Edwards of the NHS Confederation.

Liz Kendall: First, I am sure that the hon. Gentleman would never wish to put words in my mouth but I certainly never used the phrase, “Bigger is always better”. Secondly, of course providers need to develop and improve their own services, but he is highlighting another issue. DGHs will want to develop the best possible care and services they can, but should that always be led by local DGHs? If we believe that regional centres need to lead on highly specialised care, for example trauma services, do we not need a more planned approach in some cases? The Bill is about creating a much more market-led environment, in which a body wants to attract as many patients to its hospital as possible because that is what gives it the money to survive, we may end up with many DGHs attempting to develop some services that we need to be in more specialised centres. I do not think that it is an either/or, but we need some regional level planning capacity if we are to improve care.

The trouble is that it is not clear where responsibility will lie. One thing that patients and the public have always found frustrating in the NHS is finding out who is responsible. Where does the decision lie and who is responsible for taking it? The amendment seeks to make it clear that responsibility for leading the big service reconfigurations lies with the board. We may come on to whether that board should have offices at a regional level, but in the amendment the responsibility will lie with the board.

There is also an issue about consultation. If providers lead service reconfiguration, there is concern that they will not be required to consult publicly on changes to non-designated services. The Government’s response to the White Paper consultation stated that there does not have to be public consultation on changes to non-designated services. The problem is that at the moment we do not know which services will be designated. That is up to Monitor. When asked who will designate and how it will happen, Monitor, in evidence to the Committee, said that it did not know because it had not written the guidelines. This is a real issue.

Designated services could cover a very large number of hospital services, in which case it would not, in the Government’s mind, promote competition. Designated services could cover a very narrow set of services, which would allow more competition, of which, I am sure, the Government are in favour, but, in that case, there could be big changes to a lot of services without any public consultation. Will providers be able to change non-designated services without public consultation? I hope that the Minister will be able to answer that question.

The first part of the amendment gives the NHS commissioning board clear responsibility for reconfiguration. That is not to argue that it would not involve GP consortia or that the providers would not also have an important role, but if we are to make the changes that we desperately need to services such as trauma care, and make them quickly, someone should have clear responsibility. That is what the amendment delivers.

The amendment also ensures that the board will “have regard to the principles and values of the NHS Constitution” in discharging its functions. We have already debated why that should be the case. The NHS constitution was developed after many months of consultation with patients, the public and staff, and it should be placed at the heart of the board’s role and responsibility, which is what the amendment does.

11.30 am

Mr Burns: For the convenience of the Committee, I would like first to discuss the specifics of the amendment, then pick up on the points that the hon. Lady raised.

The amendments relate to giving the NHS commissioning board additional duties under clause 5 to lead in service reconfiguration in areas over which it has commissioning responsibility, and to have regard to the principles and values of the NHS Constitution. The NHS commissioning board has a strong role to play at
local level, taking into account local needs and reflecting the values of the NHS constitution in its actions. Proposals for the reconfiguration of services are predominantly a matter for the NHS locally, working in conjunction with clinicians, patients and other stakeholders. That would apply equally to changes in those services for which the NHS commissioning board is responsible.

In clause 19, under proposed new section 13L to the 2006 Act, the commissioning board would be required to involve service users when developing its plans for commissioning arrangements, just as primary care trusts and strategic health authorities are currently required to do. That includes being clear about the implications that the change may have for existing services. If the commissioning board proposed changes that would have a significant impact on the way in which services are delivered, or on the range of services available to people, it would be required to involve patients and their representatives in the development and consideration of the proposals.

The NHS commissioning board will also be an active partner in health and well-being boards. Health and well-being boards will be able to require representatives of the commissioning board to attend meetings about their local commissioning responsibilities. The commissioning board will also participate in the preparation of joint strategic needs assessments and local joint health and well-being strategies, enabling democratic and transparent input into the intentions of the commissioning board. Just like GP consortia, the commissioning board would have to consult the relevant local authority scrutiny powers would apply and the commissioning board would decide which of the services it is responsible for commissioning should be designated services. In practice, it is likely that many of the secondary care services that the board will commission need to be designated.

Clause 69 will require the NHS commissioning board to consult relevant local people and local authorities on its proposals for designating services, and to keep those decisions under review. If the board proposed to make substantial changes to designated services, the local authority scrutiny powers would apply and the commissioning board would have to consult the relevant local authority. Those duties will ensure that the board takes fully into account the needs and views of the people who deliver and receive the services it commissions, and that the commissioning board will be central to any changes affecting those services for which it is responsible. Therefore, the amendment is unnecessary.

I hope that I can offer reassurance on the second part of the amendment. We are unshakably committed to the principles of the NHS as set out in the NHS constitution. All NHS bodies will continue to be required by law to have regard to the NHS constitution when carrying out their functions. Schedule 5 to the Bill amends the Health Act 2009 so that the NHS commissioning board, and commissioning consortia, will have a duty to have regard to the NHS constitution. It is our intention that the board will play a leading role in promoting awareness of the NHS constitution across all NHS funded services.

Grahame M. Morris: Will the Minister elaborate on reports that plans to privatise a statutory health authority, the national blood transfusion service, were under consideration? How would that be affected by the provisions in the Bill and the obligations in the NHS constitution?

Mr Burns: I am sorry, but I am not sure that that point comes anywhere near the duties, responsibilities or relevance of the clause. I am intrigued that the hon. Gentleman has picked up on the relevance of the national blood transfusion service, as I do not think that is relevant to what we are discussing on reconfigurations and the national commissioning board.

The hon. Member for Leicester West mentioned two points. Will providers need to consult on how designated services—

Liz Kendall: On non-designated services.

Mr Burns: Sorry, non-designated services. I hope that it is reassuring to the hon. Lady that all providers must involve patients and the public under section 242 of the 2006 Act. That may include formal consultation, depending on the nature of the change.

Liz Kendall: That does not sound the same as the Government’s own response to the White Paper consultation which, in paragraph 5.39, says that non-designated services are “those services where providers have greater freedom to adapt in line with changing demands, for example through patient choice, without recourse to formal public consultation.” The Government’s own response to that question seems to be different from what the Minister has said.

Mr Burns: The hon. Lady quotes from that document; the public would have to be involved in the discussions of what was intended or proposed.

Liz Kendall: But someone can be involved—

The Chair: Order. The hon. Lady should be standing when she speaks—not en route.

Liz Kendall: I am sorry, Mr Hood. Of course, providers could say to patients and the public, “What do you think about this?” However, the response states that non-designated services can make changes without recourse to formal public consultation. For some people, a non-designated service might be an urgent care centre. At the moment, we just do not have any idea what could be a non-designated service in a hospital or primary community care. Although the Minister says that a large number of services will not be designated, that is not what Monitor said. It said the process had not been developed yet. I think it is very confusing.

Mr Burns: Perhaps this will be helpful to the hon. Lady. Designated services will be services designated to ensure a continuity of provision of health care, where it is envisaged that there will be only one provider in an area. The services will be designated to ensure that that service continues seamlessly.

Liz Kendall: Let us take A and E services in London. There are a lot of them—more than one. Does that mean that they will not be designated? The Minister says that they will be designated only if there is one service in the area. In north-west London or around here there are plenty of A and E departments we could go to. Does that mean they will not be designated?

Mr Burns: I do not want to give a categorical answer, for one simple reason. /Interrupt. / The hon. Member for Islington South and Finsbury harrumphs; she
has not heard the rest of the sentence. A designated service will be one to ensure that there are, across the country, the relevant services to meet people’s needs.

As to A and E, I suspect the answer is that no, in London—or, probably, in most parts of London—it will not be a designated service for the very reason that the hon. Member for Leicester West gave, which is that there is a significant number of A and E services in London. There would not be a need to designate them, whereas if one were talking, for example, about a predominantly rural area such as Cornwall, off the top of my head, A and E services would be designated, to ensure that there would be provision of that service for the people of that rural area.

That would be the pattern throughout the country. However, I do not want to anticipate which designated services will be designated, and where, because it is too soon, and frankly—to go back to the original argument about micro-management from the centre by Ministers—it will be dealt with through the commissioning board and others. I urge the hon. Lady to wait until we reach that point in the development of the reforms.

Owen Smith: Will the right hon. Gentleman give way?

Mr Burns: No, I want to finish answering the questions asked by the hon. Member for Leicester West. She referred to the role of the board on services, consults and reconfigurations. It would lead on substantial service change for those services that it commissions, such as specialised services like major trauma care, which the hon. Lady mentioned during her remarks. Unless, I am about to be picked up, I think that I have dealt with all the specific issues that she raised.

Liz Kendall: As for saying publicly that A and Es in London will not be designated services—

Mr Burns: The hon. Lady is being a little unfair. I gave that as an example because she gave it as an example. I was extremely careful to say that I would not say what services were or were not going to be designated. To be helpful to her—although I will be more cautious in future—I was giving an illustration between a very built-up, urban area and a rural area simply to get across the general point of how we anticipate designated services would work.

Liz Kendall: I thank the Minister for his intervention. I will certainly be looking forward to the wonderful accurate reporting of Hansard, where the report of our proceedings will show that the Minister said that he suspected that A and Es would not be designated in London. If that is his view, Opposition Members might disagree with it, but at least he should be consistent. When they were in Opposition, present Ministers and Secretaries of State should not have been standing behind people with placards saying that their hospitals, A and Es and maternity services would be closed if the designation of those services is not to be wide.

Mr Burns: The hon. Lady is being uncharacteristically churlish. I made it clear—Hansard will show that when we get the report—but I shall repeat it again because an untruth can get halfway round the world before truth has its boots on. I do not want to get into a situation in which the Labour party is misrepresenting what I said in general terms as an illustration to deal with that part of her speech. I took London and Cornwall as illustrative. I heavily conditioned that I was not saying that that was what would happen, but to make the point between an urban area and a rural area.

Owen Smith: Suspect.

Mr Burns: The reason why I said “suspect”, as someone in the room has just echoed like a Greek chorus, was—

The Chair: Order. I am sure that there was no Greek chorus or the Chairman would have heard it and called it to order.

Mr Burns: I am very grateful, Mr Hood, for that ruling. It was actually the hon. Member for Pontypridd, who represents one of the south Wales constituencies, so it is probably totally inappropriate to mention Greek, let alone his understanding the language.

I say to the hon. Lady that “suspect” was used as an illustration to make a point. It was not a prediction or anything else. I hope that, in that context, the hon. Lady will not seek to misrepresent what I said.

Liz Kendall: I seek neither to misrepresent, to pedal half-truths or, indeed, to be churlish. I intend to scrutinise the Bill and to make it clear to members of the Committee and, more importantly, to patients and the public what it means. What we have discovered from the debate so far—something that we will come back to when we discuss the process for designated services or lack thereof—is that it is unclear how things will happen, who will be responsible or how many services will be covered. That is at the heart of the Bill and why there are worries about the confusion about how services will be reconfigured, which ones will be protected, who has responsibility and how patients or the public will have a say.

11.45 am

There is no doubt that GPs and other health professionals have a vital role to play in deciding the future shape of services. However, when I worked with the NHS as director of the ambulance service network, a PCT within each region took responsibility for commissioning ambulance care. When that started, the PCTs had little understanding, knowledge or experience of what happened in regional ambulance service trusts, which led to a lot of frustration between providers, which would say to the PCTs, “You don’t understand what we’re doing,” and PCTs, which would say to providers, “You can’t just direct and order us around. We have responsibility for looking after patients and the public.” If there are problems, as there are up and down the country, which lead PCTs have taken the time to develop the knowledge to resolve, how many more problems will there be when GP consortia are established and set up? I am not yet convinced that the responsibility for huge reconstructions of stroke, cancer and heart disease care should lie with GP-led consortia.

The Minister has said that there are two issues.

Mr Burns rose—

Liz Kendall: If he will let me finish on this point, he has agreed and accepted that the national commissioning board will be responsible for reconfiguring services for which it has direct responsibility, such as trauma care. That is welcome, but I am talking about not just those
specialised care services but the range of other services that many patients use. It is not clear in the Bill where the responsibility lies for that reconfiguration or how the patients and the public will be consulted, which is why I shall push the amendment to a vote.

*Question put.* That the amendment be made.

The Committee divided: Ayes 10, Noes 13.

**Division No. 12**

**AYES**

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

Shannon, Jim
Smith, Owen
Thornberry, Emily
Turner, Karl
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

*Question accordingly negatived.*

Clause 5 ordered to stand part of the Bill.

**Schedule 1**

**THE NATIONAL HEALTH SERVICE COMMISSIONING BOARD**

**Liz Kendall:** I beg to move amendment 47, in schedule 1, page 221, line 13, leave out ‘Secretary of State’ and insert ‘Appointments Commission’.

The aim of the amendment is to ensure that the chair of the NHS commissioning board is appointed through an open, transparent and fair process. The Government say that they want the NHS—indeed, all our public services—to be more open, transparent and accountable, and I support that goal absolutely.

As I understand it, the Secretary of State is advertising the position of future chair of the board through the Appointments Commission. However, clause 259 will abolish the Appointments Commission.

I am sure that the Minister knows that some concerns have already been expressed about the process of appointing the chief executive of NHS commissioning board, Sir David Nicholson, but not—I hasten to add for the record—on account of any doubts about his skills, experience or commitment to the NHS, all of which I know are of the highest order. However, in response to the *Health Service Journal*, which submitted a freedom of information request on the issue, the Department said that the process for appointing David Nicholson had been undertaken without any job description, person specification or application process being drawn up. It said that the appointment was made according to an unusual recruitment process on account of the unique challenges in setting up the board.

The chief executive of the board was a direct appointment by the Secretary of State, and the concern is that if the chair were a direct appointment as well, the two key and most influential posts on the board would be appointed through a politically influenced process. The Government say they want the board to be independent and autonomous. They have made much of the fact that they want to take politics out of the NHS—we could have a separate debate on whether that is ever possible—and yet, the two key appointments on the board will be made directly by the Secretary of State.

**Mr Burns:** I am sure that the hon. Lady would like to explain to her hon. Friends that the Secretary of State will appoint only the first chief executive and that thereafter it will not be his responsibility.

**Liz Kendall:** I am sure that when the Minister responds after I have finished, he will make it clear to Members how that process will take place. I believe that the non-executives on the board will make the appointment, but the chair, the key non-executive member, who will have been directly appointed by the Secretary of State, will have key influence and say over who the chief executive of the board will be.

The amendment is intended to clarify the Government’s position. If the board is to be truly independent, why not have the chair and the chief executive properly appointed through the Appointments Commission, so that people can have confidence that they have been appointed through a fair, open, transparent and non-politically influenced process?

**Mr Burns:** As the hon. Lady said, amendment 47 would require the appointment of the chairman and non-executive members to be made by the Appointments Commission rather than by the Secretary of State. However, the Secretary of State has always had responsibility for making public appointments to both local and national health bodies. The hon. Lady knows this well because she served as a special adviser in the Department of Health in the middle part of the previous decade, working for a Secretary of State who enjoyed such powers herself. At the time, it did not seem to be a problem to the then Secretary of State or the then Government, and we share that view.

In any case, even when powers of appointment have been delegated to the Appointments Commission for the majority of public appointments, the Secretary of State has retained powers in terms of appointments to a number of the most central bodies, such as Monitor and the Care Quality Commission. In those circumstances, it has been the norm for the Appointments Commission to manage the recruitment process and for the Secretary of State to make the appointment. I am happy to confirm that that is how public appointments to the NHS commissioning board will also be handled. There will be a role for the Appointments Commission in supporting the recruitment of the chair of the NHS commissioning board, but I think hon. Members will also be aware that as a result of the review of arm’s length bodies, the Appointments Commission will be abolished. Therefore, all future appointments will be handled by the Department, as is the case now in other Departments and in accordance with guidance issued by the Commissioner for Public Appointments. For those reasons, I cannot accept the amendment, and I ask my hon. Friends to join me in opposing it if it is pressed to a Division.
Liz Kendall: In response to the Minister’s point about the Secretary of State under the previous Government—when I was privileged enough to support—having an important say in appointing the chief executive, yes she did so, because there was no independent NHS board. The Department of Health had that responsibility.

Dr Poulter: We have an independent judiciary and an Attorney-General who is appointed by the Government. How will this be necessarily different from that?

Liz Kendall: Following the Government’s logic, if they want an entirely independent NHS board, it is important that there is a fair, open and transparent process for appointing both the chair and the chief executive, which is what the amendment seeks to establish. If and when the Appointments Commission is abolished, the Department of Health will appoint the chair of the board, so how will the Department be held accountable? How will Parliament have any knowledge or scrutiny of that process? The Government cannot have it both ways, with an entirely independent board and a chair appointed by the Department of Health. Which officials within the Department would be involved? Would they not be influenced by the Secretary of State, and want to please him or her? This is such an important change, and it does not make sense that the appointment be made by a civil servant, although I am sure that many of them are independent-minded.

Mr Burns: The hon. Lady made the perfectly valid point that when she worked at the Department of Health there was not an NHS board, suggesting that the situation that we find ourselves in with the commissioning board did not exist. Will she confirm that she is aware that during that time there were other independent bodies, such as Monitor and the Care Quality Commission, the chairs of which were appointed by the Secretary of State?

Liz Kendall: That is true, but those bodies were not responsible for spending £80 billion of taxpayers’ money. I therefore suggest, gently, that the situation is very different.

Owen Smith: Does my hon. Friend agree that the key point—which I think she made a moment ago—is that it is impossible to reconcile the view that we have heard, that the board will be completely autonomous, with the fact that its head will be appointed by the Secretary of State? How is that not political interference?

Liz Kendall: As is often the case, the power and eloquence of the Welsh language puts it far better than I did.

Mr Burns: It was English.

Liz Kendall: Welsh people are far more eloquent than my good self.

Mr Burns: I am extremely grateful to the hon. Lady for giving way; let us try to help her again. What she has to understand before she comes up with conspiracy theories, or whatever, is that the process will be in line with requirements set by the Office of the Commissioner for Public Appointments, which regulates such matters. I would have thought that that, if nothing else, should satisfy the hon. Lady, if she is fair and open-minded.

Liz Kendall: I am grateful to the Minister for his help, but perhaps I may help him in return by saying that Members on this side of the Committee might want to see more open appointment processes that go further than the Government intend. We shall return to the issue later; it is important that we make some progress. We shall return to this issue later; it is important that we make some progress. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 78, page 221, line 13 [Schedule 1], at end insert—

(4) At least one of the non-executive members must have expertise or experience in relation to the commissioning of research in the health service.’.

Amendment 78, page 221, line 13 [Schedule 1], at end insert—

‘(4) At least one of the non-executive members must have expertise or experience in relation to the commissioning of research in the health service.’.

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

Amendment 19, page 221, line 14 [Schedule 1], at end add—

‘(c) a medical practitioner;
(d) a registered nurse.’.

Amendment 48, page 221, line 14 [Schedule 1], at end insert—

‘(c) at least one other member appointed by the Local Government Association, and’.

Amendment 49, page 221, line 16 [Schedule 1], at end insert ‘including—

‘(i) at least two people who are qualified medical practitioners, and
(ii) at least two people appointed by Healthwatch England to represent patient involvement.’.

Amendment 50, page 221, line 24 [Schedule 1], at end insert—

‘(4) At least one of the non-executive members must have expertise or experience in relation to the commissioning of research in the health service.’.

12 noon

Liz Kendall: The aim of the amendments is to ensure that the NHS board has the full range of voices, skills and expertise it needs to do its job properly. I want to highlight five key points. The NHS board is going to be leading the future provision of health services in this country. It is important that not only we in this House are convinced it has the full range of voices around the table, but that crucially patients, members of the public and staff within the NHS are. Winning hearts and minds is important. Feeling that one has a representative ensuring that one’s views are heard around the board is important. From my own experience—as the Minister keeps mentioning—of working within the Department, I know that that is important for people working in the system. They want to know that their voices are around the table, because they often feel they are not always heard.
I do not believe in tokenism. It would be wonderful in any walk of life if people always stood up for every one of their colleagues, but that does not always happen. The amendments seek to ensure that the people who need to be round the table are. The first seeks to ensure that a work force representative, drawn from and elected by the staff side council representatives on the NHS, staff council is on the board. Maybe the Minister will tell us if he has been to talk to the NHS staff council about the changes in the Bill. The staff council does very important work. It is crucial to work closely with the trade unions, as their members will play a big role in implementing some of the changes. The amendment calls for a representative elected by members of that council to be on the NHS board. That is very important—I am trying to be helpful—if the Minister wants to see his policies implemented. It is vital to work with the staff side council and draw on its skills and expertise.

Secondly, the amendment seeks to ensure there is a registered nurse on the NHS board. Many of us will have had strong representations from individual nurses and the Royal College of Nursing. I do not doubt that the Government believe that nurses should be involved. However, by not having it clearly specified either that the NHS board or the commissioning consortia will have a registered nurse, makes nurses very concerned. That is why the amendment seeks to clarify that there has to be a registered nurse on that board. The Prime Minister said in the Telegraph that he believes that nurses can and should be involved. I urge the Government to make that a reality by putting it in the Bill. The skills, expertise and experience of nurses are vital, as I am sure the Minister will agree. In that case, I am sure he will have no objection to ensuring that a nurse is on the board.

The third issue, addressed by amendment 48, is to have at least one other member appointed by the Local Government Association. My experience of working in the health service is that there may well always be a member from local government involved, either at local or national level. However, it is important that that is not just seen as the token local government or social care person around the table.

The fourth point, in amendment 49, is that at least two people on the board should be appointed by HealthWatch England to represent patient involvement. Having a clear voice on the board for patients and the public, appointed by HealthWatch England—if it ends up being established as a result of the Bill—which is supposed to be independent, would be a hugely important and useful addition. No doubt the Minister will say that the board will involve patients and the public, but I think that they want something more than that—they want representatives at the table.

Finally, it is crucial that at least one of the non-executive members of the board has expertise or experience in relation to the commissioning of research in the health service. One of the many brilliant things about the NHS is its capacity, which we probably have not used as much as we could have, to conduct some of the highest-quality research. I have no doubt that many members of the board will understand that, but we need someone who has far more in-depth experience of the type of research that the NHS can and should conduct, to ensure that it remains a world leader in this field. That would be hugely beneficial.

As I said at the beginning, there is sometimes a worry that there is too much tokenism, with people having places on a board who do not necessarily need to be there. However, we all know from our own experience that when we are busy and we have important things on our minds, it helps to have people there from different backgrounds and with different perspectives, who will always ensure that those concerns are heard.

Mr Burns: The hon. Lady is making an interesting case. I am just wondering what dentists, pharmacists and allied health professionals have done to upset her.

Liz Kendall: As the Minister will see when we come to later schedules and amendments, we cover these points there as well. He will see that within the relevant amendment we say that two medical practitioners should also be part of the board. I do not want the board to end up having people on it for the sake of it, but I do believe that the amendments would, by making explicit provision in the Bill, ensure that all staff and patients were fully represented and that they saw that that was happening and did not have to rely on trust alone.

Mr Burns: This group of amendments would make changes to the proposed membership of the commissioning board. I can understand the arguments made by the hon. Lady, as they all relate to how the board can best live up to its potential. I agree with hon. Members when they say that key to the effectiveness of the commissioning board will be the involvement of patients and the public and having effective working arrangements with local government.

However, what we are discussing today is the legislative framework in which the board will operate. As we have discussed in relation to previous clauses, the position of the Government is to give bodies the autonomy to make the decisions that they are best suited to make. That includes allowing the commissioning board to tailor its structures to best meet the job that it has to do.

Grahame M. Morris: I am grateful to the Minister for his generosity in giving way. I know that we are short of time. However, he did ask my hon. Friend the Member for Leicester West what we had against dentists and professions supplementary to medicine. May I pose this question to the Minister? What does he have against doctors in secondary care? We heard evidence from the Royal College of Surgeons and various others, and I am sure that there would be agreement among those on the Government Benches, that having a skilled professional with expertise in designing integrated care pathways would add value to the commissioning board.

Mr Burns: I categorically assure the hon. Gentleman that I have nothing against doctors, nurses, consultants, allied health professionals or pharmacists. Day in, day out, throughout our constituencies, up and down the country and in the devolved areas of the United Kingdom, they do a fantastic job of looking after our constituents and providing them with quality health care to the best of their ability. I am grateful to the hon. Gentleman for giving me the opportunity to put that on the record yet again. I know that my hon. Friends agree wholeheartedly
[Mr Simon Burns]

with what I have said, and I assume that Opposition Members also share my admiration for the work that those people do.

Graeme M. Morris rose—

Mr Burns: The hon. Gentleman has had his chance and he did not quite get there. However, those are not the issues that we are discussing. If the hon. Gentleman had intervened a little later, when I had developed my theme more, he might not have intervened.

Taken together, the amendments would mean that the non-executive membership of the board would have to include a medical practitioner, a registered nurse, at least one person with expertise in research, at least one person drawn from the NHS staff council and yet another person appointed by the Local Government Association. In addition, the executive members would have to include at least two further medical practitioners and two people appointed by HealthWatch.

We have repeatedly stated our intention that there should be clinical professional leadership on the NHS commissioning board. It will be vital that there is clinical input in all areas of the board’s work. Indeed, new section 13G, which will be inserted in the National Health Service Act 2006, would require the board to make arrangements with a view to securing that it obtains appropriate advice from people with clinical, professional expertise to enable it to perform its functions effectively. However, we have not sought to specify in the Bill exactly what form that should take. One role of the commissioning board is to decide that, and we trust in the decision that it will come to.

Members of the board, be they the non-execs appointed by the Secretary of State or the executive members, will in practice need a range of skills and experience appropriate to dealing with the issues faced by the board. Specifying that certain members should have particular backgrounds not only overrides the board’s autonomy, but will invite perfectly valid criticisms that one group is being prioritised over another, which could, indeed, limit the pool of experience available to the board.

When the hon. Member for Leicester West made her introductory comments, I asked about the representation of dentists, pharmacists and allied health professionals—I could go on. Do they not have just as legitimate a right as many committees as it considers appropriate and to have a range of skills and experience appropriate to dealing with the issues faced by the board. Specifying that certain members should have particular backgrounds not only overrides the board’s autonomy, but will invite perfectly valid criticisms that one group is being prioritised over another, which could, indeed, limit the pool of experience available to the board.

Mr Burns: The hon. Gentleman has had his chance and he did not quite get there. However, those are not the issues that we are discussing. If the hon. Gentleman had intervened a little later, when I had developed my theme more, he might not have intervened.

Taken together, the amendments would mean that the non-executive membership of the board would have to include a medical practitioner, a registered nurse, at least one person with expertise in research, at least one person drawn from the NHS staff council and yet another person appointed by the Local Government Association. In addition, the executive members would have to include at least two further medical practitioners and two people appointed by HealthWatch.

We have repeatedly stated our intention that there should be clinical professional leadership on the NHS commissioning board. It will be vital that there is clinical input in all areas of the board’s work. Indeed, new section 13G, which will be inserted in the National Health Service Act 2006, would require the board to make arrangements with a view to securing that it obtains appropriate advice from people with clinical, professional expertise to enable it to perform its functions effectively. However, we have not sought to specify in the Bill exactly what form that should take. One role of the commissioning board is to decide that, and we trust in the decision that it will come to.

Members of the board, be they the non-execs appointed by the Secretary of State or the executive members, will in practice need a range of skills and experience appropriate to dealing with the issues faced by the board. Specifying that certain members should have particular backgrounds not only overrides the board’s autonomy, but will invite perfectly valid criticisms that one group is being prioritised over another, which could, indeed, limit the pool of experience available to the board.

When the hon. Member for Leicester West made her introductory comments, I asked about the representation of dentists, pharmacists and allied health professionals—I could go on. Do they not have just as legitimate a right as many committees as it considers appropriate and to have a range of skills and experience appropriate to dealing with the issues faced by the board. Specifying that certain members should have particular backgrounds not only overrides the board’s autonomy, but will invite perfectly valid criticisms that one group is being prioritised over another, which could, indeed, limit the pool of experience available to the board.

Mr Steve Brine (Winchester) (Con): Is not the point that although the amendments are well put, and I understand what the hon. Member for Leicester West is saying, they rather risk tying the board’s hands? If people can go on or go off the board, that will give the chairman and the chief executive the freedom to bring in relevant expertise as and when it is needed. That is in the whole spirit of the board’s independence.

Mr Burns: My hon. Friend is absolutely right. We do not want the composition of the board to be over-prescriptive or vital sections of the health service to feel that they have been excluded because they have not had the honour of being the subject of one of the hon. Lady's amendments. If we made such provisions in the Bill and then wanted to change them, we would have to go through the whole paraphernalia of primary legislation. It is far better to have a more flexible system where the board itself can use committees to appoint people who it thinks can make—

Owen Smith: Will the Minister give way?

Mr Burns: No, not yet; I am going to make some progress. It is better if the board can appoint people who it thinks can make representations and have an input into the better working of the board.

I remind Labour Members—particularly the hon. Member for Leicester West, who introduced the concept—of comments made by her right hon. Friend the Member for Exeter (Mr Bradshaw) when discussing the proposed membership of the board of the Care Quality Commission during the passage of the Health and Social Care Act 2008. I hope and I trust that the hon. Lady will not dismiss this comparison by rather flippantly saying, “Well of course CQC is not responsible for £80 billion of taxpayers’ money.” Of course CQC is not responsible for £80 billion of taxpayers’ money, but given the old adage about knowing the price of everything and the value of nothing, one should not forget that CQC is responsible for something that is equally priceless, which is the quality of care for vulnerable people. It seems slightly flippant to have dismissed that analogy.

Liz Kendall rose—

Mr Burns: I will allow the hon. Lady to speak in a minute, when I have finished giving a rather fascinating quote from the right hon. Member for Exeter. She may not want to hear it, because she has probably anticipated that it will not be good news for her, but notwithstanding that she will listen to it and then she can respond. When talking about the proposed membership of the Care Quality Commission, which in principle is the same as the proposed membership of the commissioning board, the right hon. Gentleman said:

“Our view is that we should not be over-prescriptive regarding the make-up of the board, and the board should not be made up of delegates. We fear that other groups would then claim that their voices have as much right to be heard”.—[Official Report, Health and Social Care Public Bill Committee, 10 January 2008; c. 140.]

I find myself rather surprised to say it, but I wholeheartedly agreed with the right hon. Gentleman when he made those comments during the passage of the 2008 Act. I think that they are equally relevant today, and if the hon. Lady were as consistent as I am, she would also
agree with what the right hon. Gentleman said and would withdraw her amendments. Does the hon. Lady want to intervene, or has she given up?

Liz Kendall: It is very surprising that the Minister is attempting to give my own speeches and interventions for me. I find that peculiar. There is a difference between a regulatory body and an NHS commissioning board, but I will say that in my concluding comments.

Mr Burns: I assumed that the hon. Lady would not be able to accept the comments of her right hon. Friend. I look forward to her comments, if she catches your eye, Mr Hood, winding up the debate, but I will say in advance that, however much she may wriggle, the fact is that the right hon. Gentleman was absolutely right, and the same premise applies to the appointment of the commissioning board.

Mr Barron: If the Minister is apprehensive, as my right hon. Friend the Member for Exeter clearly was, about having a representative board—I think that will be impossible in all contexts—would he not like to see provisions in the Bill that give the board some statutory right to consult organisations that have a direct responsibility in delivering health care?

Mr Burns: If the right hon. Gentleman looks through the Bill and the White Paper, he will see considerable opportunities for consultation at all levels of the national health service and the provision of care, not only now but under the modernisation of the NHS. I do not want to get distracted and fall foul of you, Mr Hood, but what we are doing in many ways is empowering patients, which is a form of consultation, so that they too will be able to take a far more direct interest and, through the exercise of choice, have greater involvement in the provision of their health care.

Amendments 48, 49 and 78 would all involve members of the board being appointed by outside agencies. That has the serious potential to confuse lines of accountability and, indeed, to undermine the independence of those bodies. Let us take the example of HealthWatch. The Government fully support the need for greater public and patient involvement in the design and delivery of care services. Our vision for HealthWatch England is clear: to operate as the national champion for patients and members of the public, by presenting their collective consumer voice on health and social care services and influencing relevant bodies to improve the quality and safety of those services. In doing so we intend that HealthWatch England will have the power to provide advice and information on the views and experiences of patients and members of the public to, amongst other bodies, the NHS commissioning board.

Within that context, it would be entirely inappropriate for HealthWatch England to have a role in determining the membership of an organisation to which it will have a statutory power to provide advice. To place that responsibility on HealthWatch England would, rightly, lead to accusations of a conflict of interest, calling into question the integrity of an organisation, itself designed to represent the views of members of the public.

The same is true of amendment 48, which would require at least one member to be appointed by the Local Government Association. I recognise that hon. Members are seeking some reassurance that local government interests will be represented on the board, and I am happy to provide that. Clause 19 includes a duty on the board to exercise its functions with a view to encouraging integrated working between consortia and local authorities. Schedule 4 also preserves the powers in the National Health Service Act 2006 for NHS bodies, which will include the commissioning board, to enter partnership arrangements with local authorities and to make services and facilities available to them to support delivery of those services. In addition, under the new provisions in part 5 of the Bill, health and well-being boards will be able to require the commissioning board to attend meetings in relation to its local commissioning responsibilities. The commissioning board will also have a duty to participate in the preparation of the joint strategic needs assessments and local joint health and well-being strategy.

Those are the practical measures whereby we will ensure close working between the NHS and local government. I believe that they, rather than giving the Local Government Association powers to appoint members of a national board, are the way to achieve true integration. Although I am happy to confirm again that we intend there to be a wide range of experience, including clinical representation, on the commissioning board, it is not appropriate or necessary to set out in the Bill the form that should take. I ask my hon. Friends to oppose the amendments if they are put to a vote.

Jeremy Lefroy (Stafford) (Con): The national commissioning board will be an extremely powerful body. It will have control over pretty much the entire NHS budget, even if not directly, because it will be responsible for commissioning primary care services locally, or with primary care commissioning consortia, as well as those national services. As it is such a powerful body, it is extremely important that the Government’s arrangements for it are looked at carefully. I listened carefully to the hon. Member for Leicester West when she spoke to her amendments and to my right hon. Friend the Minister when he responded. I agree that the Bill is not the right place to set out specific bodies that are allowed to put forward people for the board, but the matter of the board’s accountability is not sufficiently clear. I would like the Government to consider how accountability could be better maintained.

The chair of the board is appointed by the Secretary of State, as are the other non-executive members. The Secretary of State has power to remove those members from the board in certain circumstances. We have talked about not wishing to micro-manage the NHS, and I entirely agree with that. The whole thrust of the Bill is in that direction, which is welcome, but there is a bit of a conflict in my mind—I am sure that I can be disabused of it, but I would like reassurance and perhaps some movement on it—between our wishing to get away from micro-management and at the same time having all the non-executive members of the board appointed directly by the Secretary of State, who can also remove them.

To return to the powers of the board, in his evidence Sir David Nicholson said, in response to the right hon. Member for Rother Valley, that the board would have to have people on the ground throughout the country, because it could not be expected to make decisions on Rotherham for Leeds or Burnley. The board will be very powerful and—I mean this in the nicest possible way—it will have its tentacles in every part of England.
We therefore need some clear accountability for the board. At the moment, accountability is, understandably, to the Secretary of State. I am sure that the Minister will make the point that the Secretary of State is responsible to Parliament, and that there is therefore a clear line of accountability. I would like to see a little more accountability to Parliament, in the same way that local GP consortia will be more accountable to local health and well-being boards at district level.

As suggested by the amendments, one way to do that would be for the Royal College of Physicians or the Royal College of Nursing to appoint members, or some such procedure. I agree with the Minister that that would be cumbersome and would prompt the question of who is left out, rather than of who is included, but I urge the Government to consider making the appointments—particularly of the chair, or perhaps of all the non-executives—subject to some sort of parliamentary scrutiny, so that Parliament can be assured that the make-up of the board, which is in the hands of the Secretary of State, accurately reflects what Parliament believes is in the interests of the nation, and so that that vital body can commission services as well as possible for the nation.

Liz Kendall: It is a pleasure to follow the hon. Gentleman who, as always, made a thoughtful and considered speech. I listened carefully to what he and the Minister said about not wanting every single person who might be involved in the NHS commissioning board to have a representative on it, but the experience within the NHS over a long time has been that certain groups end up dominating.

The reason why nurses feel so passionately and strongly that they want a representative on the board is that they feel that their voices have not been heard. The reason why it is important that local government should have strong representation is that, although someone from social care is often involved—just as, in the Department, we have the fantastic director general of social care—that is only one person, who always has to be the person who makes the rules known. The reason why it is important that patients and the public are on the board is that, although there are many passionate patient groups, the experience is that the professional groups sometimes dominate.

The fact that at the moment there is complete freedom for the board to decide who is represented on it worries people. The Government say that, for patients and the public, it believes in “no decision about me without me”, but that is not guaranteed in the NHS commissioning board. They say they want to involve clinicians more closely in the commissioning of services, but the Minister does not want to have medical practitioners or a registered nurse on the board. They say they want closer working with local government, but that is not enshrined in the legislation. The Minister has said that the Government’s intention is that all those different groups should be involved. If that is their intention, it should be included on the face of the Bill.

Dr Poulter: The hon. Lady makes some good points, but would not those about patient groups and their involvement be much more applicable to local health and well-being boards than to the national context where national services are being commissioned? Even in that context, would she agree that it is difficult to pick and choose which group or medical body is the one to have on the board?

12.30 pm

Liz Kendall: No, I think that there must be patient representatives on the national board, because it is going to commission certain national services, particularly for rare conditions and diseases. It is vital that we involve patients and the public in that.

On the second point the hon. Member for Stafford made about not specifying whether it is a surgeon or a GP, we do not; we say “a medical practitioner”. We are not suggesting that the Royal College of Physicians appoints one person and the BMA appoints another. That is why we have said “a medical practitioner”.

Mr Barron: I hear what my hon. Friend is saying. It is likely that representatives of the medical profession will be on the national commissioning board. What bothers me about its powers, however, is that it is going to say what ophthalmic dentistry and pharmacy services there will be in the Rother valley, and yet there is a complete absence in the Bill of anybody either sitting on the board for those primary care service providers or, indeed, having any influence in terms of having to talk to those organisations. Does my hon. Friend agree?

Liz Kendall: As always, my right hon. Friend makes a coherent point, which we perhaps should have encompassed in our amendment. On reflection, it is important to have someone from both the professions allied to medicine and the key areas that the national board will be running.

Mr Burns: And others?

Liz Kendall: The Minister asks, “And others?” but will a surgeon who is on the board or is a secondary care doctor have the in-depth knowledge to be on a national board that is going to be commissioning dentistry or ophthalmology?

Mr Burns: The hon. Lady completely forgets that the board can create committees and can put anyone with expertise in whatever field on those committees to help to guide and advise them.

Liz Kendall: My honourable good self—or however one refers to oneself in these Committees—has not forgotten that.

Mr Burns: You are ignoring it.

Liz Kendall: I am not ignoring that there are committees. First, we do not know how many committees there will be. As the Minister is keen to mirror in both foundation trusts and boards the models of governance in companies—[Interuption.]

The Chair: Order. I ask hon. Members not to chunter across the Committee.
Liz Kendall: In the really big decisions about the future shape of services, where we know that we need to see more care in the community close to people’s homes and joined up with local government and social care, those voices need to be around the table, not in a committee.

John Pugh: Would it be fair to say that there are two issues in play here? One is the question of commissioning skill; the other is the question of accountability, raised by the hon. Member for Stafford. The key question was asked a few minutes ago: what happens if the national commissioning board does not show the requisite skill? How is anybody to be made accountable for that defect?

Liz Kendall: The hon. Gentleman makes an important point. It is important that further work is done on the subject of accountability to Parliament and to the public, so that people are reassured that the right skills and experience are there. So that we can bring the matter back on Report, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 79, page 221, line 16 [Schedule 1], at end insert—

‘(1A) The appointments in sub-paragraph (1) shall be subject to the affirmation of the House of Commons Health Committee.’.

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

Amendment 51, page 221, line 27 [Schedule 1], at end insert ‘with the affirmation of the House of Commons Health Committee.’.

Amendment 52, page 221 [Schedule 1], leave out lines 28 and 29.

Amendment 80, page 221, line 29 [Schedule 1], after ‘State’, insert ‘and Parliament’.

Amendment 53, page 221, line 33 [Schedule 1], at end insert ‘with the affirmation of the House of Commons Health Committee.’.

Liz Kendall: The amendments go to the heart of the question that has been raised by my right hon. Friend the Member for Rother Valley and the hon. Members for Stafford and for Southport—

John Pugh: Did you say Stockport?

Liz Kendall: No, Southport. That question is about the accountability to Parliament of the board and the appointments process. The amendments bring together many of the concerns that have been raised today about how Parliament can be assured that the people on a board are the right people with the right skills, and that they can be held to account.

It is vital that there is parliamentary oversight of the appointments to key positions on the NHS commissioning board. As the Bill stands, the chief executive may not be appointed without the consent of the Secretary of State and the chair will be appointed directly by the Secretary of State—subsequent to present one, with which the Appointments Commission has been involved. As I said before, the two principal figures on the board will therefore be politically influenced—indeed, not driven—appointments. Several organisations have expressed concerns about that. The British Medical Association, for example, is unsure whether the board will be able to operate autonomously and be free from political control. It also says that the NHS commissioning board’s appointments process must be distanced from the Secretary of State otherwise the ability of the board to operate effectively will be severely limited.

It is clear that there is one set of questions about the independence and autonomy of the board, but for many hon. Members throughout the House, the concern is how the board can be better held to account for its actions and activities by Parliament. To ensure that the board’s appointments process is fair, these amendments propose placing a check on the power of the Secretary of State. By legislating to ensure that Parliament has the power to confirm key appointments to the board, it will help to ensure that the Secretary of State’s political influence on the appointments process is subject to proper checks and balances. It will also allow Parliament to assess whether the key individuals who will be driving change and helping determine the spending of £80 billion of taxpayers’ money are performing in the best way.

Under amendment 79, the key appointments would be subject to confirmation by the Select Committee on Health. It is important to understand that although the board itself has not yet come into existence and the way in which key officers will be appointed is only just being debated, the Government have already begun the process of making those appointments. The amendments will ensure not only that the Secretary of State has a key role, which is important, but that the appointments are monitored and endorsed by Parliament. That would lead to a more open and balanced appointment process.

Hon. Members on both sides of the House have been keen to see the role of Select Committees enhanced. As I understand it, for the first time their members are elected; that is an important development and one that hon. Members appreciate. This amendment will take us a stage further and allow—just as in the United States—the Select Committees to confirm key appointments to powerful roles. That is so important. If the NHS board is to be a more independent and autonomous body, it is vital that Members of this House, through the Health Committee, have a role in confirming those appointments.

Jeremy Lefroy: I have a lot of sympathy with amendment 79, but less with amendment 51, which would require the Health Committee to affirm the appointment of executive directors. Those appointments are to be made by the non-executive directors, who themselves will be affirmed by the Health Committee. The Health Committee’s affirmation cannot go down through all levels, but I certainly support those whom the Secretary of State appoints directly being affirmed by the Health Committee. I will give a couple of examples of where Parliament has already been given greater powers in the affirmation of such appointments—we do not seek the power of appointment.
My first example is the Treasury Committee, which has a role in affirming the membership of the Office for Budget Responsibility; my second example is the Select Committee on International Development, on which I sit, which was responsible for affirming the appointment of the chair and possibly the other members of the independent aid watchdog. There are therefore precedents for such affirmations. As a firm believer in the sovereignty of the Queen in Parliament, I believe that Select Committees, whose members are now elected, as the hon. Member for Leicester West said, should have more responsibility for scrutiny of Government. We have a good opportunity to do that. To sum up, as I have said, I have a lot of sympathy for amendment 79, but not for the amendments that are grouped with it.

Mr Burns: The amendments would change the Bill’s provision for the appointment of members to the NHS commissioning board. Once again, these amendments seem at odds with the direction of other amendments tabled by the hon. Member for Leicester West. Her amendments have consistently taken issue with our plans to promote autonomy in the NHS. We wish to remove the broad and extensive general powers to intervene in the NHS currently held by the Secretary of State and replace them with a few specific and limited powers.

The Secretary of State, of course, remains accountable to Parliament for the provision of the comprehensive health service. As I have explained on previous occasions, the Bill strengthens that accountability. For the first time, the Secretary of State will have to report each year on the performance of the health service and consult publicly on the annual objectives set for the NHS through the mandate. The commissioning board will be accountable to the Secretary of State for delivering against that mandate. These amendments would remove one of the key planks of that accountability, which is the freedom for the Secretary of State to appoint the people who will be responsible for overseeing a large proportion of the health service budget.

Amendment 52 would remove the requirement for the Secretary of State to approve the appointment of the commissioning board’s chief executive. The permanent head of the Department is the principal accounting officer and has overall responsibility for the Department’s funds and use of those funds. Chief executives of non-departmental public bodies and arm’s length bodies are appointed accounting officers in their own right to ensure that they too can be called to account for the resources allocated to them by the Secretary of State and Parliament. The chief executive of the NHS commissioning board will be the accounting officer for the commissioning budget and, therefore, it is entirely appropriate that the Secretary of State should approve his or her appointment.

The remaining amendments would require that the appointment of all members of the commissioning board be subject to the approval of the Health Committee. All Departments are required to ensure that appointments are open, transparent and made on merit. The Commissioner for Public Appointments regulates the processes by which Ministers make appointments to the boards of certain public bodies in England and Wales. That will continue to be the case, but it is not Government policy to offer confirmation or affirmation hearings for public appointments, just as it was not the previous Government’s policy to do so.

Mr Barron: On amendment 79, I sat on the Health Committee that affirmed, or at least interviewed, both the new chief executive of the Food Standards Agency and the then chief executive of the Healthcare Commission. Will that process carry on under the new structure, or will it not happen, so Parliament will not have a say on such appointments?

Mr Burns: I can reassure the right hon. Gentleman in a number of ways. Before the formal confirmation of the head of the Care Quality Commission, she went before the current Select Committee on Health to discuss how she saw her role and the way forward under her stewardship. Such a case would be up to the Health Committee. Similarly, pre-appointment hearings apply for the Independent Commission for Aid Impact, dealt with by the Select Committee on International Development. The same process applied as with the interviews for the CQC head by the Health Committee.

The process is not a right of veto, but an opportunity for hon. Members on the relevant Committee to discuss the role of the person shortly taking up an appointment. There is nothing wrong with that and some Select Committees might find such hearings extremely helpful. However, amendment 79 proposes something different.

Mr Barron: I accept that entirely. The Education Committee disagreed with an appointment, which went ahead none the less. However, why should the process not happen for the people mentioned in the Bill, who sit high up on the national commissioning board? They could be subject to the same interview process.

Mr Burns: I do not think anyone can anticipate who the Health Committee will call, for evidence or discussions. That is up to the Committee. However, I can see nothing wrong in principle with the Health Committee inviting before it, at any point in the future, the chair or the chief executive of the commissioning board to answer questions and to discuss any health matter or the board’s operations. If the Health Committee wants to invite such people before it, why should that not happen?

Mr Barron: There is a message from the seventh cavalry for the Minister. I am asking about a pre-appointment hearing, as opposed to looking at annual duties, which of course takes place.

Mr Burns: I understand that. If the right hon. Gentleman will wait half a minute as I continue what I was saying—it is in this piece of paper rather than that piece of paper—

Mr Barron: The right hon. Gentleman should have read it last night.

Mr Burns: Funnily enough, I did.

As I was saying before the first intervention by the right hon. Gentleman, Government policy is not to offer confirmation or affirmation hearings for public appointments, just as it was not the policy of the previous Government. As the Committee is aware, the previous Government introduced the current arrangements.
The Cabinet Office maintains a list of posts subject to pre-appointment hearings by the Health Committee, with which the right hon. Gentleman will be more than familiar, given that he was a distinguished Chair of the Health Committee until May last year.

Pre-appointment hearings are not binding and do not represent a power of veto, although Ministers would consider the Committee’s views before deciding whether to proceed with the appointment. The list is not set in legislation and I will not set a precedent by doing so in the Bill. Moreover, typically, only the chair of a body is subject to such a hearing, and certainly not the executive team or other staff. The effect of the amendments would, therefore, be to widen inappropriately the range of appointments included on the list.

Select Committees, of course, have an important, impartial role to play on behalf of Parliament in scrutinising Government policy. The Health Committee will be able to call a chief executive of the commissioning board to give evidence, just as they could now. That scrutiny role could be undermined if the Committee were to have a direct role in appointing the members of the board.

I repeat, after the passage of the Bill, nothing will stop the Health Committee calling the head of the commissioning board over the coming years—as I am sure will happen—to be held to account before hon. Members and to discuss a range of issues being looked at by the Committee. For those reasons, I urge my hon. Friends to join me in rejecting the amendments.

Liz Kendall: We are just beginning to have a debate about how the important and powerful board could better be held to account by Parliament. Undoubtedly, given our discussion of this and previous amendments, it is necessary to at least strengthen accountability to Parliament to ensure that the key people who will have a powerful influence on the future of health and social care in this country are better held to account.

The hon. Member for Stafford made an important point about amendment 79—I accept it, and will consider some of his suggestions—and said that the others could be better. My right hon. Friend the Member for Rother Valley made the important point in his intervention on the Minister that we need the chair or chief executive to come before the Health Committee not just after they have been appointed but for a pre-appointment and affirmation process.

There is scope for both sides to reconsider how the board should be held accountable to the House. That is certainly what Opposition Committee members intend. I acknowledge fully that the previous Government might not have given Select Committees rights as strong as they might have had over appointments, but I think that that is where we should go in future. As a constructive Member of Her Majesty’s Opposition, I believe that that is what we should be seeking to do in the Bill. More work needs to be done on that point. I urge it on Members on both sides; we will certainly do so. The amendment needs further work and reintroduction on Report, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): I beg to move amendment 54, in schedule 1, page 222, line 11, at end insert—

‘(3A) Any person removed under the terms of subparagraph 4(3) has the right of appeal to the Tier 1 Tribunal.’.

The Chair: With this it will be convenient to discuss the following: amendment 55, in schedule 1, page 222, line 15, at end insert

‘with the agreement of the Board Chairman’.

Amendment 56, in schedule 1, page 222, leave out lines 16 and 17 and insert—

‘(5) A person shall be appointed as a non-executive member for a period of 4 years.’.

Amendment 57, in schedule 1, page 223, leave out lines 27 to 31.

Amendment 81, in schedule 1, page 223, line 31, at end insert—

‘(4) The remuneration, payments and compensations in sub-paragraphs (1), (2) and (3) shall be subject to scrutiny by Parliament, by whatever method it may decide.’.

Tom Blenkinsop: I speak in support of the amendments, following the excellent arguments made earlier by my hon. Friend the Member for Leicester West. The amendments are designed to shed light on what look like yet more hurried elements of the Bill by addressing procedure or the lack thereof, the Secretary of State’s leverage and how it might be kept in check.

Amendment 54 reads:

“The Bill gives the Secretary of State the power to remove or suspend a non-executive member of the NHS commissioning board whenever he or she deems necessary on grounds of incapacity, misbehaviour or failure to carry out his or her duties. However, the Bill does not make it explicit whether the non-executive member has the right to appeal. At present, no appropriate checks and balances have been built into the Bill. At the very least, the amendment does not undermine the powers prescribed for the Secretary of State and applies a necessary, moderate and just check to those powers to ensure that justice may be served for all parties involved.”

Tier 1 or first-tier tribunals are generic tribunals with jurisdiction over a range of appeals. In other words, they are not specific to one area of appeals, such as immigration, pensions and so on. The tribunals cover a number of health matters, and first-tier tribunals include a health, education and social care chamber. First-tier tribunals are also mentioned in various other parts of the Bill in relation to appeals against rulings. Without the amendment the Bill looks arbitrary and lacking in due process rather than liberating.

Amendment 55 inserts

“with the agreement of the Board Chairman”.

My colleagues and I fear that without a requirement for the explicit, unqualified agreement of the board chairman, neither the appropriate board chairman nor the board will have the means to operate autonomously, free of direct micro-management, political influence and top-down control by the Secretary of State. The NHS commissioning board process must retain, maintain and sustain a degree of autonomous accountability for decisions on any appointments and dismissal procedural decisions. It is crucial that a degree of checks and balances on the Secretary of State’s powers are clear, so that the board
[Tom Blenkinsop]

and its chair remain suitably distanced from the Secretary of State. Otherwise, the ability of the board to operate effectively and transparently will be severely limited. This amendment, for example, avoids a potential conflict of interest where a Secretary of State has power to impose regulations on the NHS commissioning board and consortia without the board's consultation or agreement. Where disagreements between boards and Secretaries of State occur, it will be fundamentally crucial for a board's chair to work in partnership, not in subjugation, with the Secretary of State, otherwise trust and partnership in the arrangements disintegrate in and outside the board.

Amendment 81 restores transparency to the process, and ensures that Parliament can act as the appropriate body to provide the necessary oversight for any recommendations brought by the Secretary of State. The Bill has neither any examples of what a Secretary of State may have in mind, nor a scale of remuneration, which only leads me to the conclusion that it would be brought to bear in an arbitrary, or indeed ad hoc, fashion by the Secretary of State. Will the Minister give us a structure, or an example, of what a Secretary of State might have in mind? Can he give us scales of remuneration that a Secretary of State could turn to, or what models of best practice, to which the Minister may refer, could be stipulated? Any such answers would be helpful.

Mr Burns: I congratulate the hon. Gentleman on his first speech from the Front Bench in this Committee. I am sure we look forward to hearing from him many times in the future.

Emily Thornberry: We are collective, collaborative.

The Chair: Order. In 10 minutes, hon. Members can carry on their conversations, but not in the Committee.

Mr Burns: As the hon. Gentleman said, this group of amendments deals with matters concerning terms of appointment, remuneration and functions of non-executive members. Once again, the amendments seem to run counter to the arguments made by Opposition Members, that the Secretary of State should be personally accountable for the provision of services in the NHS. They would remove the Secretary of State's powers to hold the non-executives on the board accountable for their conduct and performance, and to determine their pay and remuneration. Before I deal with the individual amendments, I should point out that the provisions on appointments and dismissals of non-executives, as set out in the schedule, are common to many arm's-length bodies. They do not represent radical new policy and are similar to procedures carried out under the previous Administration.

Amendment 54 would require there to be a right of appeal to a tier 1 tribunal where a non-executive is removed from office. The Bill sets out clear criteria for the Secretary of State to remove a non-executive member on the grounds of incapacity, misbehaviour or failure to carry out his or her duties as a non-executive member. Those criteria are common across other arm's-length bodies within the remit of the Department of Health. They do not include statutory rights of appeal, because non-executive appointments do not represent an employment contract. The usual employment legislation, therefore, does not apply. Nevertheless, we would expect that all reasonable routes would have been exhausted before the decision to dismiss someone was reached. If taking a decision to remove someone from office, the Secretary of State would have to act fairly and reasonably in any event. The standard procedures that currently apply in practice require that the individual should have the chance to request a review of the recommendation and to make their case in writing before a final decision is reached, and we would expect that to continue to be the case. Ultimately, the non-executive would have the right to challenge the decision to remove them from office by way of a judicial review.

Amendment 55 would require the Secretary of State to secure the agreement of the chair of the board before suspending a non-executive member.

1 pm

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

Adjourned till this day at Four o'clock.