PUBLIC BILL COMMITTEE

HEALTH AND SOCIAL CARE BILL

Tenth Sitting
Tuesday 1 March 2011
(Afternoon)

CONTENTS

Schedule 1 agreed to.
Clauses 6 to 18 agreed to.
Adjourned till Thursday 3 March at Nine o’clock.

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The Committee consisted of the following Members:

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

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 1 March 2011

(Afternoon)

[Mr Jim Hood in the Chair]

Health and Social Care Bill

Schedule 1

THE NATIONAL HEALTH SERVICE COMMISSIONING BOARD

Amendment proposed (this day): 54, in schedule 1, page 222, line 11, at end insert—

‘(3A) Any person removed under the terms of sub-paragraph 4(3) has the right of appeal to the Tier 1 Tribunal.’.—(Tom Blenkinsop.)

4 pm

Question again proposed. That the amendment be made.

The Chair: I remind the Committee that with this we are discussing 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.’.

The Minister of State, Department of Health (Mr Simon Burns): As you will remember, Mr Hood, before we adjourned for lunch, I was starting to discuss amendment 55, which would require the Secretary of State to secure the agreement of the chair of the board before suspending a non-executive member. The chair is also capable of suspension themselves under paragraph (4)(3) of new schedule A1 to the National Health Service Act 2006, so in practice the amendment would make its operation difficult, if not impossible. It is accepted practice, however, that references to the appointments committee or to the Department of Health to suspend a non-executive director are normally made through the chair. In situations in which the reference is not made through the chair, the chair may be contacted to discuss the matter and to give their view on the referral. Ultimately, however, the decision must rest with the Secretary of State as the person responsible for the appointment of non-executives.

Amendment 56 would fix the term of appointment for non-executive members at four years, rather than up to four years. A four-year appointment is usually made, but such flexibility means that it can be tailored to suit the particular circumstances of the individual or body concerned. In addition, the code of practice set by the commissioner for public appointments states that a non-executive’s total period in office must not exceed 10 years. It is important that appointment terms are flexible so that that requirement can be met.

Amendment 57 would remove the board’s duty to pay compensation to a person who ceases to be a non-executive member if the Secretary of State considers there to be exceptional circumstances. We do not intend to use that power to provide golden handshakes upon resignation. There may be exceptional circumstances in which a non-executive is no longer able to continue in office through no fault on their part and in which it may be appropriate to pay compensation, but they will be rare, so this is an exceptional power. I must therefore resist the amendment.

Amendment 81 would ensure that there was parliamentary scrutiny of the remuneration, pensions, allowances or other gratuities payable to non-executive members. As far as I am aware, this would be the first time that Parliament had a direct role in such matters. The Bill provides, quite rightly, for the Secretary of State to determine such matters to ensure consistency with other Department of Health arm’s length bodies, such as Monitor and the Care Quality Commission, and to avoid any tendency for unjustifiable packages to be offered by the board.

The packages that the Secretary of State may determine are, in practice, subject to wider cross-governmental approval through the public sector pay committee. That process was put in place for all proposals on public sector pay by the previous Administration, who considered it to be an adequate and proportionate mechanism for determining public sector pay. We agree with that view, so we do not think that there is a need for additional parliamentary scrutiny of the pay of the board’s non-executives. I hope that Labour Members will also agree that the mechanisms that their Government put in place are still relevant today.

I think I have responded to all the points arising from the amendments. Provided that the hon. Member for Middlesbrough South and East Cleveland is satisfied with my explanation, I urge him to consider withdrawing his amendment. If he decides to press it to a Division, I shall ask my hon. Friends to join me in opposing it.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): I thank the Minister for his reply. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Tom Blenkinsop: I beg to move amendment 58, in schedule 1, page 224, line 5, at end insert—

‘(1A) The Board must appoint a committee whose remit includes consideration of and, where appropriate, the discharge of the Board’s duty under section 13I (duty to promote research).’.

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

Amendment 85, in schedule 1, page 224, line 7, at end insert

‘but may not include persons who are providers of services that the Board commissions, or representatives of such persons’. 
Amendment 86, in schedule 1, page 224, line 13, at end insert—

(4) The membership and function of each committee shall be published.

(5) The dates and agendas of meetings shall be published before meetings, and minutes recording decisions made shall be published after meetings.2:

Amendment 87, in schedule 1, page 224, line 13, at end insert—

Conflicts of interest

1 (1) The Board shall make provision for dealing with conflicts of interests of members of the Board, its committees or sub-committees, its employees, and any person with which it has a contractual arrangement to exercise or assist its exercise of its functions.

(2) The provision shall include a register of interests.

(3) The provision must be approved by the Secretary of State and laid before Parliament.1.

Tom Blenkinsop: I shall focus on amendments 85 and 87.

Without amendment 85, the Bill suggests that the board can appoint anyone that it likes to do anything that it wants. One could say that that makes it quite the quango but without any of the necessary checks. Amendment 85 would provide oversight on who the appointed people may be or what function or role they may perform. Without the amendment, there could be a huge lack of clarity in the checks and balances on whom the board appoints.

If a sub-committee dealing with a specialised field appointed someone from the private sector, which is quite conceivable given the limited field of people in certain specialist areas, or an academic who was funded by the private sector, who would provide the necessary check and accountability structure for that appointment? Of course, many members of the private sector are sought to advise working groups, but they are accountable and held in check at present. If there is no check in place, it is quite conceivable that the distinction between commissioning and provision could become blurred on such specialised sub-committees. Amendment 85 would provide such a check. It would not discriminate against any sector—indeed, advice would still be sought from all sectors—but it would provide clarity on the distinction between commissioning and provision and, importantly, a safety of structure for anyone taking part in such sub-committees.

Amendment 87 could apply not only to members of the board, but to consultants and private sector accountancy firms that will provide business support to all tiers of the structure, including the board, consortia, Monitor, the Department of Health and commissioned services. The amendment would be particularly important if subcontracting took place because it would provide for full transparency from the start to the end of that process. A declaration of interests for any committee or sub-committee member, or anyone whom they may employ, would be a basic and necessary element required by not only parliamentarians, but our constituents. Amendment 87, like amendment 85, would bring clarity to the blurring lines between commissioning and provision.

Indeed, the Minister, back in his days as a senior member of the Health Committee in 2005, voted for a register of interests for all prescribing doctors. Does he agree with such an argument in principle now?

Mr Burns: I thank the hon. Gentleman for describing me as “senior”, but he will find that, certainly following the 2005 general election, I was not a member of the Health Committee. Even when I was a member of that Committee, I am unaware of ever having voted on anything because, under the splendid leadership of Mr Hinchcliffe, we did not have votes—everything evolved as a consensus.

Tom Blenkinsop: I apologise to the right hon. Gentleman, but I was referring to his ministerial colleague, the hon. Member for Sutton and Cheam. I was simply making the point that a register of interests for such a body would bring transparency to the process, so it is a necessary inclusion.

John Pugh (Southport) (LD): Nothing has yet been said about amendment 58 which, if I understand it correctly, sits rather uncomfortably with the other amendments, which relate to transparency, declarations of interests and so on. The purpose of amendment 85 appears to be to separate providers and commissioners, while amendment 87 would insist on very clear rules on declarations of interest and amendment 86 would insist on there being open meetings in which things could be as transparent as possible. Coupled with those is amendment 84, which has been withdrawn, which would apply the Freedom of Information Act 2000 to the proceedings of the commissioning board. I should like to say a little about each of those areas.

I draw attention to amendment 58 because, like other members of the Committee, I attended an event last night at which the topic was medical research. NHS research has an enormously important pedigree and many people at the event had been involved in it for a long time. They are extremely worried, so they have lobbied the Department of Health about a number of issues connected with what might transpire under the Bill, as well as the regulatory burden on them, some of which comes for Europe and some of which is in-house. They are worried that GPs may not recognise the importance of medical research in their plans.

That has huge clinical repercussions, and given the importance of medical research to this country and the pharmaceutical industry, the researchers were keen to labour the point that it has huge economic importance. When a Minister at the event was roundly accosted on the subject, the researchers were given some comfort that clinical research will not be forgotten, as the amendment would ensure. If it is not the amendment that will give them comfort, however, it is incumbent on the Department of Health to give them comfort in some other form. It is worth drawing attention to that aspect of the NHS because it might be overlooked during the scrutiny of the Bill.

Amendments 85 and 87 are slightly contradictory. Amendment 85 would remove conflicts of interests simply by removing providers from commissioning—that is one solution. Amendment 87, perhaps owing to an acceptance that that will not happen, would ensure that conflicts were dealt with in a thoroughly ethical and transparent way. I have more sympathy with amendment 87, because it is really hard to have an absolute commissioner-provider split. The danger is that people end up being involved in the commissioning of services with which they have no familiarity because they have never provided
them themselves. That happens time and time again within the medical field when the commissioner-provider split is too rigidly enforced. In any case, GP commissioning to some extent blows a hole in the commissioner-provider split and we are apparently prepared to live with that.

Amendment 86 addresses open meetings, which is one of the ways in which conflicts of interests can be best dealt with. While one can set up a procedure, one really wants to know that that procedure is followed and that it is apparent to everyone who takes an interest in the matter. I do not think that the Minister would have any difficulty suggesting that the NHS commissioning board could be subject to the same requirements as those in the Public Bodies (Admission to Meetings) Act 1960, which applies to local authorities and the like. After all, that is a tried and trusted remedy and one with which the Government might, without too much persuasion, be quite comfortable.

Going back to the topic of research, I forgot to make a point that needs to be stressed: many of the important research projects in the NHS in recent years have been progressed in, through or via the strategic health authorities. They have played an important role in pulling together threads of research which is why, even though I do not think it is likely that amendment 58 will be agreed to, it is worth airing the topic in Committee.

4.15 pm

The Minister of State, Department of Health (Paul Burstow): It is a pleasure to serve under your chairmanship, Mr Hood.

The amendments in the group relate to the separate issues of research and transparency, which are both legitimate areas to explore in Committee. I wish to reassure the hon. Member for Middlesbrough South and East Cleveland and respond to some of the comments made by my hon. Friend the Member for Southport. I do not think it would be appropriate or conducive to the effective fulfilment of the board’s functions to prescribe who should or should not be allowed to sit on a committee of the board, or to exclude providers of services or those representing them, as proposed by amendment 85. My hon. Friend set out a well-made point about the possible perverse consequences of not involving providers in discussing how services might be commissioned. That is not to say that there should not be strong governance arrangements around interactions between providers and commissioners to ensure that they are subject to proper probity and to provide transparency around other potential conflicts of interest within the board.

A number of things should help to provide comfort to the Committee as well as security when the Bill is enacted. Paragraph 12 of new schedule A1 to the 2006 Act will allow the board to regulate its own procedure. It is intended that that will enable the board to determine its own internal governance procedures to address issues such as managing conflicts of interest, for example by preventing executive members from being involved in determining their own pay or ensuring that providers who may be involved in a particular committee are not involved in decision-making processes around commissioning decisions. We have to expect a level of maturity in which the importance of co-operation and collaboration among bodies involved in the health service is balanced with clarity about the rules that will apply.

The hon. Gentleman asked about provider involvement. The prohibitions in the Bill provide an added protection against anti-competitive conduct, while we intend to make regulations under clause 63 to ensure that proper procurement practices are followed and to protect choice and competition. Those regulations could include specific procedural requirements to ensure that commissioners carry out fair and transparent practices, and they might in particular make requirements concerning managing conflicts between the interests involved in commissioning services and those involved in providing services.

Reference has been made to the distinction between commissioning and provision. It is important to put on the record that the distinction is provided mainly by the approach in the Bill of creating clarity about the roles of different bodies in the system. That is why the board will have responsibility for commissioning services only, rather than also for supporting provider trusts, as is currently the case with SHAs.
On another aspect of the hon. Gentleman’s amendment, board members of non-departmental public bodies are expected to follow a code of practice based on the Cabinet Office’s model guidance, covering their role and responsibilities, conduct issues and addressing conflicts of interest. Non-executives must also adhere to their terms and conditions of appointment, and as part of that they are expected to demonstrate high standards of corporate and personal conduct and should follow the seven principles of public life, the so-called Nolan principles.

The principles are not statutory, but that does not mean that they have no force. Most public bodies have incorporated them into codes of practice and other internal standards that can then be taken into account, for example, in cases before the relevant ombudsman. We would expect the NHS commissioning board to do the same. Indeed, many of these principles are reflected in the current guidance for the NHS, “The Healthy NHS Board: Principles for Good Governance”, which sets out guiding principles for board members to understand their collective role, their governance role, activities and approaches to improved board effectiveness and the contribution expected of them as individual members of the board. We remain committed to the principles that were set out in that guidance.

On transparency, which was touched on by my hon. Friend the Member for Southport in respect of the way in which the board discharges its functions, my hon. Friend is absolutely right to draw attention to the easy way in which we could make sure that the NHS commissioning board meets in public and fully discharges those responsibilities. We will table a Government amendment to include the NHS commissioning board as a body to which the duty in section 1 of the Public Bodies (Admission to Meetings) Act 1960 applies. This would require the board to hold meetings in public, subject to certain exceptions and administrative requirements of the sort that, as a former councillor, he will know apply in local authorities as well.

Under that Act, the board may only exclude the public from a meeting, or part of a meeting, if publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or for other special reasons. Provisions in the Act would also require agendas and papers for meetings to be made publicly available. Although I agree with the principles behind the amendments, for the reasons I have explained, and given the fact that other parts of the Bill deal with many of the issues, and that there is a specific undertaking to table a Government amendment, I hope that the hon. Member for Middlesbrough South and East Cleveland will withdraw the amendments. If he chooses not to, however, I will encourage my colleagues not to support him.

Tom Blenkinsop: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment 90 would make explicit, as the hon. Gentleman said, that when a Member of Parliament asks the Secretary of State a written parliamentary question, about, for example, how the NHS commissioning board carries out its functions, the Secretary of State would be provided with a power to require that information from the board. I entirely agree that it is necessary for Members to be able to hold the Executive to account, and to be able to ask questions that are of interest to their constituents, as the hon. Gentleman described.

As we have set out, we are trying to provide additional opportunities for Parliament to scrutinise the way that both the Secretary of State and the NHS discharge their responsibilities in the new architecture. I would like, therefore, to reassure the hon. Gentleman that his amendment is unnecessary, because paragraph 14 of new schedule A1 to the 2006 Act requires the board to provide the Secretary of State with such information as he considers necessary for his functions. That, of course, includes the Secretary of State’s role in being accountable to and answering questions in Parliament. Many of the Secretary of State’s existing powers will be directly conferred on a number of bodies in the new architecture, which include, for example, the NHS commissioning board, the economic regulator and the CQC. Their roles and responsibilities, including those of the Secretary of State, are clearly defined in the Bill. Inevitably, that will lead to an altered role for Government, which will include less interference on a day-to-day basis from Ministers in operational decisions relating to the NHS. Ministers, however, will continue to be accountable to Parliament through parliamentary questions, Adjournment debates, or Select Committee hearings. The Bill in no way changes that position.

I hope that that commitment will reassure the hon. Gentleman that his amendment is unnecessary and that he will withdraw it. If not, I urge my colleagues not to support the amendment.

Tom Blenkinsop: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.
Liz Kendall (Leicester West) (Lab): I beg to move amendment 59, page 226, line 24 [Schedule 1], leave out ‘if the Secretary of State so directs’.

The Chair: With this it will be convenient to discuss amendment 60, page 226, line 26 [Schedule 1], leave out ‘if the Secretary of State so directs’.

Liz Kendall: The amendment covers interim accounts, which may not sound like the most riveting topic, but it is important.

The amendment relates to paragraph 17 of new schedule A1 to the 2006 Act, but I want to refer to the previous paragraph briefly, as it will help to explain why the amendment has been tabled. Paragraph 16 relates to the board’s annual accounts:

“The Board must prepare consolidated annual accounts in respect of each financial year.”

That would cover the board’s own annual accounts and those of each commissioning consortium. The board must then send copies to the Secretary of State and the Auditor General, as well as laying them before Parliament, which I think is absolutely right.

The interim accounts still have to be examined by the Auditor General, but they must only be sent to the Secretary of State if the Secretary of State directs the Auditor General to do so. I am not sure how that works. If the Secretary of State has not seen the interim accounts, how can he decide whether the Auditor General should send them to him? Furthermore, the accounts only have to be laid before Parliament if that is directed by the Secretary of State.

The point is important, because it is about parliamentary overview and scrutiny of NHS finances, both of the board and the commissioning consortiums. Under the previous Government, there was the chief executive’s annual report, which included information on the finances, as well as quality of care and whether various targets were being met. Although that was done regularly, the previous Government also moved towards providing quarterly reports. That is important, because it is about parliamentary scrutiny. The intention is to improve the system with the agreement of the Treasury, to ensure that there are opportunities to monitor the financial position of all NHS bodies. The intention is to improve and extend accountability and parliamentary scrutiny, so the decision as to whether the board’s in-year accounts should be audited would be at the discretion of the Secretary of State, in recognition of the time and costs involved. In the event that the in-year accounts are audited, it may not be necessary for the Comptroller and Auditor General to send a copy of the report on the accounts to the Secretary of State or to lay copies of the accounts and the report before Parliament in every case. So the Bill provides for the Secretary of State to have the power to direct that that should happen.

It is absolutely not the intention of the Bill to avoid public scrutiny. The intention is that that information would be in the public domain. There is no intention to avoid public scrutiny through this arrangement. Indeed, it is a novel arrangement to ensure that there is more information about the financial performance of consortia, of the NHS commissioning board and of the board’s annual accounts. The NHS commissioning board will have independence over the allocation of resources, it will be accountable to the Secretary of State for its financial management and for the value for money that it is achieving with NHS funding.

Paragraph 17 of new schedule A1 to the 2006 Act, which the amendment addresses, gives new powers to the Secretary of State, with the approval of the Treasury, to require the NHS commissioning board to produce interim accounts for a specified period in addition to annual accounts. The NHS commissioning board will sit within the Department of Health’s resource accounting boundary and therefore it is essential that the Secretary of State, in discharging his accountability to Parliament, is able to monitor the financial position of organisations within the NHS.

That is a new power, which is being introduced across the system with the agreement of the Treasury, to ensure that there are opportunities to monitor the financial position of all NHS bodies. The intention is to improve and extend accountability and parliamentary scrutiny, so the decision as to whether the board’s in-year accounts should be audited would be at the discretion of the Secretary of State, in recognition of the time and costs involved. In the event that the in-year accounts are audited, it may not be necessary for the Comptroller and Auditor General to send a copy of the report on the accounts to the Secretary of State or to lay copies of the accounts and the report before Parliament in every case. So the Bill provides for the Secretary of State to have the power to direct that that should happen.

It is absolutely not the intention of the Bill to avoid public scrutiny. The intention is that that information would be in the public domain. There is no intention to avoid public scrutiny through this arrangement. Indeed, it is a novel arrangement to ensure that there is more information available in-year about the way in which NHS organisations and bodies are operating. So it is not the case that we are attempting in any way to reduce the scope for parliamentary scrutiny.

Grahame M. Morris (Easington) (Lab): So that we can assess the size of the potential problem in terms of having proper checks and balances and financial scrutiny, have the Government done any assessment of what the failure rate is likely to be, in percentage terms, for GP consortia or indeed for foundation trusts?

Paul Burstow: I will happily return to the hon. Gentleman with a proper answer to that question rather than giving an off-the-cuff answer to it, but the reason that this provision is in the schedule is to ensure that there is more information about the financial performance of consortia, of the NHS commissioning board and of
other parts of the system, provided in a timely fashion, both for parliamentary purposes and to enable the Secretary of State to discharge his responsibilities in accounting for the use of public money.

Having given those assurances and reassurances, I hope that the hon. Member for Leicester West will be sufficiently reassured not to press the amendment to the vote. If she does press it, I would encourage my colleagues not to support it.

**Liz Kendall:** I hope the Minister acknowledges that I am not arguing that the schedule represents a step back. That is not the point that I was making. My point is that it is important to publish or lay before Parliament interim accounts of a board and consortia that are responsible for £80 billion of taxpayers’ money. The Minister explained that he will not accept the amendment because of time and costs, but I think they would be well spent on providing that information to Parliament. MPs would wish to see whether their consortia are financially stable or whether there are problems, particularly if the consortia are not required to publish their board minutes as I think, primary care trusts currently are. That is the contrast with what PCTs currently have to do—publish that information. I do not believe that GP consortia will be required to do so, which is why it would be even more important that interim accounts are published.

**Paul Burstow:** I reiterate to the hon. Lady that all we are trying to avoid, in gathering the information as part of the interim accounts process, are the costs of audit and other associated costs incurred in the system twice a year. It is not that the information will not be available for parliamentary or public scrutiny.

**Liz Kendall:** However, that is not what will be avoided here, as the Comptroller and Auditor General will have to conduct scrutiny of those accounts anyway. That is what the schedule says. The point is that once that has happened—the money has been spent and the audit has been done—the interim accounts should be published. I will seek to press the amendment to a vote, as I think it is vital that we have such scrutiny of public money, and I urge hon. Members on both sides of the Committee to support it.

**Question put,** That the amendment be made.

The Committee divided: Ayes 7, Noes 13.

**Division No. 13**

**AYES**

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

**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.

Schedule 1 agreed to.
[Grahame M. Morris]

“a duty needs to be placed on the national commissioning board and the consortia to embed shared decision making in all care and treatment”.

Surely it is only by reinforcing the duty on the commissioners themselves to reduce inequalities that we have any chance of achieving it. Dr Hamish Meldrum of the British Medical Association was asked about equitable access to health services, and he said that it would be

“the articulate, the new-media savvy, who will do well. Those who are less like that will not.

It is not so much what is in the Bill or not in the Bill, but what is happening elsewhere and how much the Bill will help to address that—and I do not think it will be very much.”—[Official Report, Health and Social Care Bill Public Bill Committee, 8 February 2011; c. 19 and 39, Q41 and 88.]

The advice that we are being given is that the Government have not put safeguards in place to reduce health inequalities. Competition is likely to play a negative role and harm the equality of service, unless we reinforce or place a duty on consortia to put reducing inequalities ahead of competitive forces.

This is a probing amendment—we will not vote on it, as far as I understand—so I seek clarification and information from the Minister. What assurance can he give that if inequalities rise under the new arrangements between regions, between consortia or even within consortia, if they are large, mechanisms will be in place to reverse them? If such mechanisms will be in place, can he identify them?

4.45 pm

What powers will the local authority and the health and well-being board have to ensure that a GP consortium is following the strategies that have been agreed and set out—especially in relation to reducing inequalities? Finally, where a GP consortium crosses a local authority boundary, how will that affect the co-ordination of services? Clearly, there could be a conflict as it follows two separate strategies for two different patient groups.

Mr Burns: I congratulate the hon. Gentleman on what I think is his first appearance on the Labour party’s roving Front Bench. [Interruption.] I have no doubt that it is combative and, in various ways, collaborative. It is also in various ways a joy to listen to the different contributions from hon. Members. It is good sense to lock in different members of the Committee and for them all to play their part. I congratulate the hon. Member for Easington on what is a first for him. No doubt he will continue to entertain the Committee during future sittings as and when his turn comes.

The only problem—to spoil the bonhomie slightly—is that this debate is in some ways a regurgitation of a lengthy and important debate that we had on clause 3. I do not know whether the hon. Gentleman was not present at the time, but he certainly did not seem to learn from what was said then. The Government members of the Committee are as committed as the Opposition members to reducing and minimising inequalities in the NHS. If one had not listened to the debates on clause 3 but just listened to the speech of the hon. Member for Easington, one would come away with the view that that was not the case when in fact it is.

Grahame M. Morris: I do not want to drag this out, but I would like to set the record straight. The debate on clause 3, although it was about health inequalities, was about placing a duty on the Secretary of State. This debate is about placing a duty on the consortia, so fundamentally, although some of the arguments are the same, it is different in nature.

Mr Burns: I fully accept the first part of what the hon. Gentleman has said. Obviously, he is factually correct, but the point is that the nub—the core—of the debate is about driving down inequalities in the NHS and I think that I can say without fear of contradiction that all right hon. and hon. Members in this room are united in seeking to achieve that. I fully accept, as my hon. Friends do, that this is a very important subject. I wholeheartedly agreed with the hon. Member for Islington South and Finsbury, who said in the debate on clause 3 and inequalities:

“Our national health service is a manifestation of that commitment to equality.”—[Official Report, Health and Social Care Public Bill Committee, 17 February 2011; c. 297.]

I appreciate the interest that all hon. Members have taken in this area. However, I am not, I am sad to have to tell the hon. Member for Easington, convinced that the amendment is necessary. I appreciate that he sought to anticipate part of my speech and I take my hat off to him. He is absolutely right: I will quote clause 22 to him, because that is crucial to the argument and how we accomplish the aim of driving down inequalities, particularly in relation to consortia. We already place duties on GP consortia in relation to the need to reduce inequalities. As the hon. Gentleman rightly identified, that is in clause 22, which inserts proposed new section 14N into the National Health Service Act 2006 and reflects equivalent duties given to the Secretary of State and the commissioning board.

I note that Opposition Members do not seek in this case to name individual aspects of inequality or to impose impossible duties. In one way we have made a step forward in our arguments, because they have not sought to reiterate what they did with their amendment to clause 3, which were rightly defeated for the reasons given at the time.

Hon. Members will be pleased to see that this duty goes further than that which the hon. Member for Easington proposes in his amendment, which is rather ironic given his comments. Given our previous debate on the Secretary of State’s duty to reduce inequalities, I know that Opposition Members will agree with our proposal that this duty obliges consortia to “have regard to the need to—

(a) reduce inequalities between patients with respect to their ability to access health services;

(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services” in the exercise of their functions—the functions in this case being those of GP consortia.

By placing this less comprehensive duty forward in the Bill it is no more of a duty for consortia than any other conferred upon them by this legislation. It is far better with the consortia’s other duties. I hope that what I have just said will persuade the hon. Member for Easington not to press his amendment. If he reflects further, what we are doing strengthens the
battle—for want of a better word—against inequalities, and the desire and drive to reduce and minimise inequalities in the provision of health care at all levels, whether it be GP consortia, the national commissioning board, or the Secretary of State.

Jeremy Lefroy (Stafford) (Con): I listened to and fully agreed with what the Minister said, but I wonder why the hon. Gentleman felt it important to move this amendment in regard to the commissioning consortia when there was no parallel amendment in regard to the national commissioning board, which would have made sense to me.

Grahame M. Morris: We tried to place a duty on the Secretary of State, who would have had overall responsibility in this regard, but given that 80% of services will be delivered through GP consortia it seemed sensible to place such an obligation on them at this opportunity. However, we have received particular assurances that new section 14N, inserted by clause 22, deals with this. We have exercised the arguments and will come back to some of these things later in the debate, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.
Clause 6 ordered to stand part of the Bill.

Clause 7

THE SECRETARY OF STATE’S DUTY AS TO PROTECTION OF PUBLIC HEALTH

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 20, in clause 7, page 4, line 15, leave out from ‘take’ to ‘for’ in line 16 and insert ‘appropriate steps’.

This is simply moving from a subjective test to an objective one. The BMA is concerned that proposed new section 2A(1) does not go far enough in ensuring that it is a statutory requirement that the Secretary of State take appropriate actions in regard to protecting public health. Amendment 20 simply strengthens the requirement on the Secretary of State to protect public health, rather than leaving it to him to take such action as he thinks is appropriate according to his whim. It would make a small but significant change and therefore I urge the Minister to accept it.

Paul Burstow: The amendment would have the perhaps unintended consequence of weakening and confusing the role of the Secretary of State with regard to the duties to protect public health that the Bill places on him. Several of our exchanges in Committee have suggested that Opposition Members wish the Secretary of State to be even more accountable to Parliament for the discharge of a wide range of responsibilities. The amendment, however, would create confusion about what is or is not an appropriate step for a Secretary of State to take.

New section 2A gives the responsibility for that decision clearly to the Secretary of State, who will therefore clearly be accountable to Parliament for the exercise of his responsibilities under the Bill.

The amendment would blur that responsibility by removing any indication of who decides what is appropriate and who would therefore be accountable for such decisions. As the new section stands, the accountability is unambiguously the Secretary of State’s. Were amendment 20 to be agreed, we would have less clarity, while the clarity that currently exists would be removed. Of course, the Secretary of State will take expert, evidence-based advice before making those decisions and must make a proper assessment that takes all the relevant factors into account. That is precisely why the Bill paves the way for the creation of Public Health England within the Department and as part of its functions. In the light of my comments, I ask the hon. Lady to withdraw the amendment. If she does not, I shall urge my colleagues to vote against it.

Emily Thornberry: May I take the Minister through how the amendment might work in practice? If the new section was amended, it would mean that if the Secretary of State was exercising his or her discretion but doing so in a way that is wrong, negligent and lazy, and that did not really understand the true nature of public health, he or she may be accountable to Parliament. In practice, however, what would that mean if we wanted to ensure that the Secretary of State did not behave in such a way? We could judicially review their decisions much more easily if the measure was a little clearer and had an objective test, as opposed to a subjective test, because a defence within a court of law against a lazy Secretary of State who is not doing his job properly, when people are dying, would be to challenge him in court by saying that he is not doing his job properly. That is why we need a tougher law—we are talking about law here—that makes things clear in a way that any Englishman can understand.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 12.

Division No. 14]

AYES

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

NOES

Brine, Mr Steve
Burston, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot
Lefroy, Jeremy
Morris, Grahame M. (Easington)
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

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

The Chair: With this it will be convenient to discuss new clause 1—Public Health England.

Emily Thornberry: The new clause draws attention to the existence of Public Health England and its functions. Its purpose is to allow us to discuss the changes to responsibilities for public health. We are scrutinising this massive Bill, but it does not include what everyone agrees is probably the most crucial area of health—public health. That is where health starts, yet we have overlapping time scales of key elements of the Government’s policy on health and their reform agenda. That means that some issues remain unresolved in the Bill, and most
importantly in public health. The Bill does not mention the responsibilities of Public Health England, and how it will co-operate with the national commissioning boards or GP consortia, or how it fits in with the health and wellbeing boards. That is half of the jigsaw, and seems to be missing.

There are many criticisms of the Government, and how they are pushing this legislation through in a forced and hurried way, and this is another reason why they should stop, take stock a little, and consider health as a whole. Because they are pushing this risky legislation through so quickly, they are doing so without properly putting together how public health fits in with the new structures that they want.

I do not know whether the Minister has read The Lancet today, but concern is expressed by health academics that putting Public Health England within the Department for Health risks losing public trust. We have seen under Governments of different colours several difficulties in relation to public health in a political connection—for example, the bovine spongiform encephalopathy crisis and Ministers feeding their daughters burgers, and when Labour was in Government the measles mumps and rubella vaccine crisis, and whether children should be given it. That illustrates how political involvement may sometimes undermine public trust.

That important debate should happen, but it cannot be rushed through at the moment, in the middle of the Bill. The Government are consulting on public health and the appropriate approach but—I repeat my earlier point—they are consulting on that while still pushing through the Bill, and it is as though they are fighting on our behalf for health with only one hand instead of both. In the original White Paper, the subsequent legislative framework and the next steps document, the Government indicated that the Bill would establish the basic legal architecture for Public Health England, so we want to know why that is not being done, given that it was promised in the White Paper, the legislative framework and the next steps document.

Paul Burstow: As this is a clause stand part debate, I shall start by saying a little about the clause. It gives the Secretary of State a new general duty to protect the health of people in England. It lists some examples of steps to protect health that the Secretary of State might take, and ensures that he liaises with the Health and Safety Executive on radiation protection.

The clause is fundamental to the strategy for public health signalled last year in the coalition programme for government and set out in greater detail in the White Paper “Equity and excellence: liberating the NHS”. The strategy has been broadly welcomed across the sector.

The duty underpins a major component of the new public health service—Public Health England, to which the hon. Lady referred—by making the Secretary of State directly accountable for protecting the health of the people of England. Taken alongside other provisions in the Bill, it will unify vital functions currently undertaken by different organisations, maximising the flexibility and transparency of services while putting clear responsibility for the protection of the nation’s public health at the heart of national Government, where it belongs. It reflects the fact that for the first time, there is a cross-Government Cabinet Committee to deal with public health matters, which brings public health to the centre of Government policy making.

In our view, new clause 1 is superfluous and would create an entirely unnecessary degree of bureaucracy within a system that the Bill seeks to simplify and streamline. Clauses 7 and 8 give the Secretary of State new duties and powers to protect and improve the health of the people of England.

Emily Thornberry: Is it right that the Government intend to introduce Public Health England at some stage?

Paul Burstow: Public Health England will be a state function of the Department of Health, so it will not be established by primary legislation. It will be a function discharged within the Department of Health.

Emily Thornberry: So although the Government are currently consulting on their strategy on public health, they have already decided that there will not be a body independent of the Department of Health called Public Health England, because that body will be within the Department of Health?

Paul Burstow: The consultation does not pose the in-principle question of whether the organisation should be the subject of primary legislation. We made it clear earlier, during the publication of the White Paper and the Command Paper, that we see Public Health England as a central part of the function of the Department of Health and a rebalancing of the Department’s responsibilities to focus much more clearly on the public health aspects of the Secretary of State’s responsibilities.

That is why we think that new clause 1 does not assist, because the Bill does not create a new legal entity called Public Health England. It is not our intention that it should. Instead, Public Health England will become part of the Department of Health, as I said, which will put it right at the heart of the Government, where it should be. From the outset, its functions will include those that the Bill confers on the Secretary of State. The Secretary of State will be directly accountable for those duties and will establish Public Health England within the Department to discharge them.

Emily Thornberry: I am genuinely confused about the Minister’s approach. In the legislative framework and the next steps document, did not the Government indicate that the Bill would establish the basic legal architecture for Public Health England?

Paul Burstow: The Bill does. These two clauses place clear and specific duties on the Secretary of State. Indeed, clause 8 places specific duties on local authorities. That is how the architecture for delivering public health will be taken forward. The Department of Health will organise itself with a new responsibility, Public Health England, to discharge those functions on behalf of the Secretary of State, but the Secretary of State has the duty and will be responsible for it.

As such, Public Health England will be directly accountable to the Secretary of State. That is deliberate, as we want the new system to be more flexible, adaptable and responsive. The hon. Lady’s new clause would, for example, require the Secretary of State to use secondary
legislation every time he wanted Public Health England to undertake a new function or end an existing one. Public Health England within the Department will be expected to provide impartial, objective, expert advice of the sort to which she referred, and to be an exemplary service.

The new clause does not offer any extra degree of independence in practice, if that is what the hon. Lady was seeking. The future of Public Health England is secure; the new clause would simply wrap it in layers of red tape. I therefore urge the hon. Lady not to press new clause 1, but to consider the results of the consultation, as the Government will do, because we are committed to ensuring a much clearer focus on public health than in the past.

**Emily Thornberry:** I am grateful to the Minister for casting some light on the issue.

*Question put and agreed to.*

*Clause 7 accordingly ordered to stand part of the Bill.*

**Clause 8**

**DUTIES AS TO IMPROVEMENT OF PUBLIC HEALTH**

**Emily Thornberry:** I beg to move amendment 24, in clause 8, page 5, line 5, leave out ‘such steps it considers appropriate’ and insert ‘appropriate steps’.

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

Amendment 22, in clause 8, page 5, line 7, leave out ‘may’ and insert ‘must’.

Amendment 25, in clause 8, page 5, line 7, leave out ‘may take such steps as the Secretary of State considers appropriate’ and replace with ‘must take appropriate steps’.

Amendment 23, in clause 8, page 5, line 9, at end add ‘where the Secretary of State, after consulting with local authorities, is satisfied that such steps are more appropriate at national rather than local level.’.

**Emily Thornberry:** These are more amendments that would just change words, but essentially beef up the power vested in the clause by changing “may” to “must” and a subjective test to an objective test, which we believe is necessary. We do not want the unnecessary use of words in relation to such important issues. We want responsibility to be clearly understood by all parties.

Amendments 24, 22 and 25 would make changes to clause 8 similar to those that amendment 20 sought to make to clause 7. The Secretary of State must take such steps as necessary, and the weasel words must be taken out of the clause. Amendment 23 would make it clear whose responsibility is what and ensure no offloading of responsibility. For example, there is concern that the Secretary of State might offload responsibility to local authorities when, in fact, the responsibility should be a national responsibility. The amendment would make things clear and deliberate so that the Bill helped to ensure better public health.

**Paul Burstow:** I am sure that we have common cause in the desire to improve the health of the nation. Where we part company is on whether the amendments would have their intended effect of beefing up the clause or the unintended effect of diluting it. The amendments would confuse the roles of both the Secretary of State and local authorities. They repeat the error of amendment 20 by creating an unnecessary uncertainty over what is or is not the appropriate step for local authorities to take when acting to improve the health of their populations.

Clause 8 is clear. The decision should be the local authority’s. It knows its people; it is directly accountable to them, and will have the benefit of a director of public health offering appropriate advice. Like amendment 20, amendment 24 would take away that clarity, making the decision about what is appropriate that of no one in particular. In that sense, it would confuse accountability and make it less clear who was responsible. Local authorities will consider expert evidence-based advice before making such decisions and they must make a proper assessment, taking into account all the relevant factors. That is precisely why the Bill requires local authorities to appoint directors of public health.

Amendments 22 and 25 would be especially confusing. The power conferred by the clause on the Secretary of State can be used to support local authorities throughout England as a whole or in one particular location. We expect that the latter situation would be unusual, but the amendment would give the Secretary of State the same duty as local authorities, undermining at a stroke the key principle of putting local authorities in the lead in improving public health.

As for amendment 23, the Secretary of State’s powers under clause 8 could be exercised locally as well as nationally, but when the Secretary of State needs to intervene nationally it follows that he would believe that that is appropriate action to take. Again, a blanket requirement to consult local authorities would be cumbersome and significantly slow down an urgent response.

There seems to be inconsistency in the amendments. They show a lack of faith in both the Secretary of State and local authorities to use their judgment to determine the appropriate steps to take, yet elsewhere it seems that there is a resistance to the creation, for example, of the NHS commissioning board and a policy of freeing the NHS from central control by Ministers.

I suggest that the hon. Lady withdraws the amendment. If she does not, I urge my hon. Friends to resist it.

5.15 pm

**Emily Thornberry:** My counter-arguments are similar to those I used when we debated a previous clause. Some hon. Members present may feel that putting the matter to a vote is to travel in hope, but I constantly travel in hope. I hope that Government Members have listened carefully to the arguments and had a chance to digest them properly. I hope that they will vote for the amendment.

*Question put,* That the amendment be made.
The amendment is designed to confirm what Ministers have been saying because the Bill does not state that the budget will be ring-fenced. The success of the plans outlined in the public health White Paper, “Healthy lives, healthy people”, depends on public health budgets being fully protected to prevent crucial health-related functions from being squeezed by other demands.

Devastating cuts have been made to local authorities. Clearly, local authorities are going to need to make very difficult decisions, and they would not be human if they did not look to public health budgets to see whether some holes in their other budgets could be plugged as a result of the new funding that may be coming to them. If the Minister confirms that the budget will be ring-fenced, it is important for us to understand what functions will come within that.

For example, can the Minister define what public health is and what it would be appropriate or inappropriate to spend the money on? One example that is constantly debated is whether, during a cold snap, when the roads and pavements are icy, it would be appropriate to use the public health budget for gritting. Surely, if the pavements are gritted, the elderly will not fall over and break various limbs.

Could public health budgets be moved towards budgets that may be losing some of their funding as a result of Government cuts? That example may sound facetious, but it is genuinely being debated by people in local government, because there is so little guidance on what responsibilities they will have, what public health means, and what powers they will have.

Emily Thornberry: I beg to move amendment 67, in clause 8, page 5, line 9, at end insert—

‘(2A) The Secretary of State must identify funding to be passed to local authorities for the purposes of taking steps under subsection (1).

(2B) Such funding passed to local authorities may only be spent on activities consistent with subsection (1).’

I call this the ring-fencing amendment. Although a responsibility or duty is being placed on local authorities in relation to public health, the concern is that they may be being set up to fail. It is unclear what duties they will have, what public health is, how much money they will have and what powers they will have. Although good will and good intentions lie behind the clause, the powers are not sufficiently clear and that is what we wish to examine through the amendment. If local authorities are to be given control over improving public health in their areas, they must be properly resourced and there must be an indication as to what they should be spending their money on.

A figure of £4 billion for the entire public health budget has been cited, but there is no indication about how that will be split between Public Health England and local government. We have heard today that Public Health England is possibly going to be part of the Department of Health, and it may be unclear how the split will happen. Local government could end up with maximum responsibility for public health outcomes, but with less than half the budget. Local authorities need to know what their responsibilities and budgets are likely to be, and I would be grateful for some indication about the Government’s plans.

The amendment is designed to confirm what Ministers have been saying because the Bill does not state that the budget will be ring-fenced. The success of the plans outlined in the public health White Paper, “Healthy lives, healthy people”, depends on public health budgets being fully protected to prevent crucial health-related functions from being squeezed by other demands.

John Pugh: The hon. Lady is moving a very helpful probing amendment, which I hope will stimulate some debate. The understanding of public health within the health service is slightly different from that in the local authority context. For example, the larger part of the public health budget now goes on vaccination and so on, and local government officers will not be involved with that in any way. It would be interesting to know, when that budget is taken out, what budgets and what functions will transfer.

Emily Thornberry: There is also an argument that the public health budget could be used for new roofs so that people do not have to live in damp local authority flats, with the resultant bad health outcomes. We need some guidance, and we need to know who will give it and how it will work.

Another factor that is causing some concern and confusion among people in local government is the proposal for the health premium, which raises a number of questions. Does the Minister intend to pursue the policy set out in “Healthy lives, healthy people”—to remove the extra funding from deprived areas if they do not progress fast enough to improve public health? I refer in particular to paragraphs 4.32 to 4.34, which say: “To incentivise action to reduce health inequalities we will introduce a new health premium, which will apply to the part of the local public health budget which is for health improvement...local authorities will receive an incentive payment, or premium, for these services that depends on the progress made in improving the health of the local population...The health premium will be funded from within the overall public health budget. Potentially, an area that makes no progress might receive no growth in funding for these services. We intend the support for progress in reducing health inequalities to be clear and significant.”

That is another element that is clearly causing great concern in the local authority community, and I wonder whether the Minister can cast a little light on it so that we can better understand what the funding means and how it will work.

Jeremy Lefroy: I have one question for the Minister. It relates a little to what the hon. Lady was just saying, but perhaps more specifically to services that we might identify as health services, as opposed to gritting roads.

New section 2B(3)(c) of the 2006 Act, which clause 8 inserts, is about...
“providing services or facilities for the prevention, diagnosis or treatment of illness”. I would appreciate clarification from the Minister on where the dividing line is between services provided by what we understand is the NHS—through consortia or the national commissioning board, which would, I imagine, envisage that such services are their duty—and where the responsibilities of local authorities and the Secretary of State lie in respect of clause 7.

Mr Kevin Barron (Rother Valley) (Lab): I rise to support this amendment. My hon. Friend the Member for Islington South and Finsbury says that it is a ring-fencing amendment, and in its intention it is exactly that. The moneys that will be paid down for public health matters to local authorities will be ring-fenced and will only be able to be spent in the way that is laid out in subsection (1) of new section 2B. May I say, Mr Hood, that you and I have had a long-standing interest in public health in this Parliament that probably stretches over two decades?

Subsection (1) of new section 2B is a massive move for public health—I do not disagree with it—and it states:

“Each local authority must take such steps as it considers appropriate for improving the health of the people in its area.”

We have never been very good at population health in this country. In my experience, measuring population health is normally done by counting the numbers of people who become a patient in the national health service as opposed to looking at the population and being able to see what should be happening. The intent of new section 2B(1) is to do that.

My hon. Friend asked whether local authorities could spend money on improving a damp council flat. The explanatory notes—page 17, paragraph 115—go into some detail about the definitions in the Bill. They say that duties on local authorities should include “giving information to the public about healthy eating and exercise, providing facilities for the prevention or treatment of illness such as smoking cessation clinics, providing financial incentives to encourage individuals to adopt healthier lifestyles”.

One example is to give people a financial incentive to stop smoking during pregnancy, because we know that that affects the foetus and then the child for many years. Housing is also mentioned.

It is crucial that new section 2B(1) is stuck to and that we measure how health is improving in the population. As I have said, we have never been good at doing that. Will the Minister tell us what will be put in place to ensure that local authorities are not only delivering things that they believe will better the health of the population that they represent but will measure this so that there is some consistency? If one local authority is doing something that is working in its population, we could then follow that best practice in neighbouring authorities or those further afield. I am deeply interested to have that on the record now. How does the Minister feel that this Bill will interact with our population to improve the health of the public as opposed to just looking at individuals?

Paul Burstow: I thank the right hon. Gentleman for his remarks. It is right to identify the fact that by providing local authorities with this welcome new duty, we have opened up an opportunity. A couple of the remarks that were made during the evidence session bear testament to the fact that this change is welcomed by many organisations and people outside this House. Perhaps it is worth putting them on record. Andrew Cozens, who is strategic director, children, adults and health services at the Local Government Association, said:

“What we welcome and have very substantial evidence of is the contribution that local government can make to the health of the public, which I think is distinct from the public health functions, some of which are quite technical and are best organised at a national level. Local government invests considerably in those services, both directly and indirectly.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 59, Q125.]

Dr Gerada, chair of the Royal College of General Practitioners, said:

“Again, I think that putting public health within the local authority—I am speaking as a GP now, not as public health clinician; they may have a different view—is a good idea. Some 60% of what we see in our consulting room cannot be affected by anything that we can do.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 49, Q101.]

There is a real opportunity, and one way in which we have tried to recognise that is through early publication of a public health strategy and of an outcomes framework for public health. For the first time, we will set out a whole series of metrics that we can use to drive forward a public health agenda.

5.30 pm

We will respond to the consultation once it closes. We see it as a tool for driving not only a public health agenda but, by looking at it across the health and social care outcomes frameworks that are also being published, for having a more integrated, collaborative and co-operative approach to how services are commissioned.

I have several responses to make to conclude the debate, but I will start with amendment 67, which was moved by the hon. Member for Islington South and Finsbury. She will not be surprised if I say that the amendment is not necessary. Clause 8 will make no provision for the funding of local authority public health services, since it will be administered under section 31 of the Local Government Act 2003. That section allows Ministers to make grants to local authorities, to attach conditions to the use of grants and to specify circumstances in which the grants would have to be repaid. That is consistent with how other local authority grants have been administered until now, and we see no reason to depart from that.

We are committed to using those provisions to make ring-fenced grants for public health purposes to each type of local authority defined in clause 8. We are currently consulting on how best to make that funding system work and on the conditions that we should attach to grants. That consultation, which is due to end on 31 March, covers questions such as which services the ring-fenced grant should fund, and how money might be allocated to local authorities. Importantly, it covers the questions asked by the hon. Lady about the design of the new health premium. We do not have a closed mind. We are waiting for the results of the consultation before finalising the design of the health premium, which will reward success in improving outcomes and encourage local actions.
The hon. Lady asked for clarification about the definition of public health. It is worth noting that past legislation on public health and the responsibilities of the NHS for public health have never given a clear definition. The Bill goes further than any previous Government have tried to do in setting out what public health is all about. That is why clause 8 will insert new section 2B in the National Health Service Act 2006, setting out several steps that local authorities and the Secretary of State may take in certain circumstances. That provision does not attempt to capture the whole rich variety of possibility that should be available to local authorities in discharging the public health duty. It does not attempt to constrain local authorities, but none the less it gives a sense of what we are trying to capture in the duty.

Emily Thornberry: My right hon. Friend the Member for Rother Valley pointed out that the explanatory notes list several of the actions that local authorities might be expected to take to further public health. It ends with the example of helping “individuals minimise risks to health arising from their accommodation or environment for example a local authority may wish to improve poor housing where this impacts on health.” Can the public health budget be spent on new roofs for social housing in a local authority area?

Paul Burstow: The hon. Lady has read from the explanatory notes, which are a key part of the interpretation of the intention of Parliament when it legislates. She has helpfully put on record part of the policy intention behind the clause, which should be used to interpret it in the future; that is the purpose of explanatory notes.

The hon. Lady asked about the powers in the Bill, which has been broadly drafted to allow flexibility at a local level. Specific functions are covered in later clauses. Without flexibility, we risk the creation of unhelpful distinctions, and local authorities should keep their existing health protection duties. As I have already said, previous legislation was less clear. She also asked for a definition, specifically in relation to the gritting of roads. The primary function must be to improve public health. Road gritting may have a public health benefit, but that is not its primary purpose. It should be carried out under other local authority powers.

I stress that we are consulting at the moment on the scope and the commissioning routes for public health. The consultation has listed examples of public health functions and has asked whether they are appropriate. It would be wrong at this point in the legislative process for us unnecessarily to fetter local authorities in exercising the discretion that they will have in discharging their duty as the Bill will provide for them.

On the dividing line between the NHS and public health, no arbitrary divide is provided on purpose. Clauses 7 and 8 set out steps that the Secretary of State or local authorities may take, and they are examples that are offered to give a sense of the flexibility and the possibilities. The mandate, which we will come to later, to the NHS that the Secretary of State will set to the NHS commissioning board will set out the public health priorities for the NHS. Again, we are clear that although the NHS cannot necessarily deliver a public health agenda on its own, it clearly has a contribution to make and we want to ensure that it does so.

The hon. Lady asked about the health premium, and the answer is no. We are consulting now on how the funding regime will work, but the distribution of the grant and how it will work is still a matter for decisions that have not yet been made. The health premium will provide additional incentives and resources to those local authorities that show that they can make the most progress for their residents.

Following up on one final point, PCTs have a general function, which is touched on in the point about how PCTs have discharged public health responsibilities in the past. The Bill is more specific, and it imposes a specific duty on local authorities.

I hope that I have provided some clarity and some reassurance about our intention that this is a ring-fenced grant, and the mechanism by which it will be delivered.

Mr Barron: Quality standards are being laid down by NICE regarding the commissioning process of consortia and others that may come up from time to time with the flexibility. Will such standards—not necessarily NICE standards on public health, although it does that—be passed down to local authorities, with the expectation that they will run their public health programmes to those standards?

Paul Burstow: One of the functions that one might expect Public Health England to be providing is necessary collaborative working with its colleagues in local government. The approach that we envisage for taking public health forward will certainly involve that sort of collaborative approach. As the right hon. Gentleman has said, it is desirable that we pick up and disseminate good practice quickly and Public Health England will certainly play a part in doing that.

John Pugh: Following on from what the Minister has said, I was relieved to find that a great deal of consultation and consideration is involved in this. Clearly, differentiating public health is a very difficult area that has many manifest aspects to it. There appears to be scope for the Government to be more definite in some respects, maybe not in the context of this legislation but at a subsequent point, because two issues are raised here. First, the hon. Member for Islington South and Finsbury has teased at, there is the question of whether in fact at certain points some of the money that is spent in public health could be regarded as ultra vires. In other words, if the local authority spends money some people may question whether it is on public health, or if money is taken from the public health budget people may argue whether it should be or whether it can be. Secondly, where does responsibility lie for specific things? Thanks to the right hon. Member for Rother Valley, my attention was drawn to the explanatory note. It contains a statement to the effect that one thing that is encompassed in public health is: “providing facilities for the prevention or treatment of illness”. The only example of that is: “such as smoking cessation clinics”, which are very distinctive entities.

Grahame M. Morris: To be helpful, I can think of an excellent example that was piloted in my area and perhaps tried elsewhere, when our PCT addressed an
issue of trips and falls, particularly among older people, and purchased some non-slip slippers. That seemed rather bizarre, and was reported in the papers, but it reduced the incidence of broken neck of femur by I do not know how many percent. There is value in such an approach in terms of the outputs that can be delivered by such an expenditure of resources.

John Pugh: Yes, there are many excellent schemes. I am simply asking whose responsibility it is to establish them, disseminate them and so on. Something that could be included in the facilities for the prevention or treatment of illness is, for example, a well woman clinic in a deprived area. However, there might be a debate locally about who should provide it—should it be the health authorities or should it be the local authority? The Government might be happy for them to sort that out among themselves on a local basis—the funding is another matter—but, at some point, there will be an issue across the country regarding who legitimately should finance an active programme or whether it should be co-financed?

Jeremy Lefroy: I would like to support what my hon. Friend is saying and reiterate the point that certain services might fall under either heading—under public health or under the provision of normal health services through consortia. I shall give one example. Does he think that the preventative measures taken in respect of bowel cancer would fall under public health or would they be the responsibility of commissioning consortia?

John Pugh: I am not speaking for the Government, but my instinctive reaction is that it would fall under the health body. We have no clear way of answering that. I accept the fact that we cannot reach a definitive answer until the consultation process is finished—it would be premature to do so—but, at some point, there needs to be some fairly clear adjudication and a form of adjudication that will work in practice. We have not got there yet.

Emily Thornberry: This has been a very interesting and important debate, which shows how much work needs to be done on the issue. Local authorities are losing huge amounts of money. In the next three years, our local area will lose £338 million. Frankly, if the person in charge of housing hears that the public health budget might be available to be used to do up roofs for social housing in Islington, I would be concerned that he will make a strong bid for some of the public health budget in order to be able to pay for that. The difficulty is that this new ring-fenced budget has been introduced at a time when local authorities are starved of cash. There will be a temptation for those budgets to be raided, so it is very important that this problem is addressed and it is made clear what these funds are to be used for. My great concern is that we may end up without the money being used in the way that is envisaged at the moment. It is easy for us in the slightly arid environment of the Committee in Westminster to think that everything will be fine, but it might not be. In any event, the debate has also thrown up the fact that it is very difficult to define public health. Local authorities will not only be starved of cash, but will be trying to fulfil a public health duty at a time of economic decline, which has, of course, itself had an impact on public health.

Paul Burstow: Although it may be difficult, that is surely a task to which we should commit ourselves. That is why we are consulting. I re-emphasise to the hon. Lady that section 31 of the Local Government Act 2003 provides for conditions to be attached to the giving of grants. By introducing a ring-fenced grant, it is our intention to attach such conditions to deal with the very concerns that she is raising.

Emily Thornberry: I am grateful to the hon. Gentleman. As I say, the concerns expressed this afternoon are genuine and I certainly hope that, in introducing the legislation, the Government will ensure that they are addressed. I do not intend to press the matter to a vote. I beg to ask leave to withdraw the amendment. Amendment, by leave, withdrawn.

5.45 pm

Emily Thornberry: I beg to move amendment 129, in clause 8, page 5, line 16, at end insert—

“(ca) providing services or facilities designed to promote early diagnosis of cancer;”.

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

Amendment 130, in clause 8, page 5, leave out lines 17 and 18.

Amendment 131, in clause 8, page 5, line 20, after “their”, insert “employment,”.

Amendment 29, in clause 8, page 5, line 25, at end insert—

“(t) supporting research into the prevention, diagnosis or treatment of illness.”.

Emily Thornberry: Amendment 129 is a probing amendment that has been promoted by Cancer Research UK, which is rightly concerned about the effect of the reforms on cancer care. It argues that the amendment would add the function of providing early cancer diagnosis services to the list of functions of local authorities and the Secretary of State. The reason for the amendment is that commissioning for cancer is complex. There are more than 200 kinds of the disease, and the average GP would see only eight or nine new cases of cancer each year. To commission effectively, commissioners require information about the appropriate levels at which to commission certain services, what an excellent service looks like, and the current quality of different services. GP-led commissioning could lead to some loss of the expertise that has been developed to support commissioners, and Cancer Research UK would like reassurance that the support of cancer experts will be sought by commissioners during the transition to new commissioning arrangements and beyond.

Amendment 130 is also a probing amendment. It would take out “providing financial incentives to encourage individuals to adopt healthier lifestyles”. The reason for that is that we would like to know what kind of incentives are envisaged. That is of great interest, given the Government’s track record. Many will remember
their snatching the health in pregnancy grant from women, and if that is not an appropriate financial incentive, what is?

Amendment 131 would insert “employment” after “their”, and the reason is self-evident. As it stands, the clause correctly notes that people’s housing and general environment are major causes of ill health but it ignores their employment, which can have a considerable impact, in particular the safety of the working environment, the promotion of a healthy lifestyle within the workplace—for example, the provision of facilities—or directly in terms and conditions such as flexible working time, time off for health checks and ensuring that pay is sufficient to sustain reasonable health.

For many people, their workplace and work are as important in determining their overall health as their home or general environment, and that should be recognised so that councils have a clear steer to have regard to it. Examples might include the Prime Minister’s suggestion that businesses provide facilities allowing their employees to cycle rather than drive to work, and the campaign which I believe a member of this Committee has supported for workers to be allowed time off for cancer screening. Other examples involve health and safety, decent wages and good industrial relations generally. Councils can take many steps to promote good practice in all of those fields, so the amendment seeks to add employment to the list, which is entirely reasonable.

Amendment 29 would add paragraph (h), “supporting research into the prevention, diagnosis or treatment of illness”, to the list (a) to (g) in subsection (3), which lists some of the steps to improve public health that the Secretary of State and local authorities could take. The amendment would explicitly add research to the list. The Breast Cancer Campaign raised this point with me, and I would be grateful if the Minister could clarify whether research is covered by the current wording of the subsection, and whether it should be included in the Bill. The explanatory notes state in paragraph 115 on page 17: “Subsection (3) of the new section lists some of the steps to improve public health that local authorities and the Secretary of State would be able to take. These include carrying out research into health improvement”.

Research seems to have been missed from the list. Is that a mistake? If it is, can we have it added to the list, please? If it is not, could the Minister explain exactly what is happening with it? Those are all the points I wanted to make on the amendments.

Paul Burstow: I am sure that the intention behind the amendments is to ensure that the Bill does what we are saying it does. However, again, the amendments in this group are superfluous. They are either unnecessary, or unnecessarily restrictive or possibly risk stifling innovation in public health, which we are trying to encourage.

Let me be clear that the list of steps in new section 2B(3) that clause 8 inserts in the National Health Service Act 2006 is not exhaustive. The steps are examples intended to illustrate to local authorities and to the Secretary of State how the new duty to improve public health might be executed, but without defining it in an artificially restrictive way. The fact that a particular step is included does not mean that it must be taken. Similarly, the Secretary of State and local authorities will be able to provide services that are not on the list, which is why we are consulting, as just discussed in the debate on the previous amendment.

I will take each of the hon. Lady’s amendments in turn. On amendment 29, the Bill already includes specific provision for the role of the Secretary of State and the local authorities in health research. Reading from page 5 to page 10 of the Bill, we find that clause 13(14) amends schedule 1 to the National Health Service Act 2006, to give local authorities the power to “conduct, commission or assist the conduct of research” connected with their health service functions, which would include public health and health improvement. The same subsection of clause 13 gives the Secretary of State an equivalent power to “conduct, commission or assist the conduct of research into… any matters relating to the causation, prevention, diagnosis or treatment of illness, and… any such other matters connected with any service provided under” the 2006 Act “as the Secretary of State…considers appropriate.”

I hope that power is sufficiently widely drawn to enable such matters to be dealt with. Local authorities and the Secretary of State will be able to assist and support the research referred to in the amendment.

I can also give the hon. Lady the assurance she was seeking, I think on behalf of Cancer Research UK, about the necessity of ensuring appropriate clinical advice sought during the transition and beyond in the commissioning of cancer services. Beyond the transition, the NHS commissioning board will be deciding how to discharge the duty to seek such assistance.

Amendment 129 would add early diagnosis of cancer to the list of steps. The list as it stands in clause 8 cites the prevention and diagnosis of illness—in new section 2B(3)(c)—which clearly includes cancer. A separate reference to cancer, and only cancer, does not change the effect of the clause but poses the question of why cancer alone should be highlighted in this manner. Now I understand the source of the amendment, I understand why only cancer is addressed, although I appreciate that that is not the intention of Cancer Research UK—

Emily Thornberry: It is a probing amendment.

Paul Burstow: Indeed. I hope my assurance that the clause deals with the concern will reassure the hon. Lady and the sponsors of the amendment. Meanwhile, the equivalent list in clause 7, illustrating the Secretary of State’s new health protection duty, also specifies screening services, which includes cancer screening.

The early diagnosis of cancer is dependent on health protection and health improvement activity, which is why the clauses as drafted open the way for effective collaboration and co-operation between the national and local levels of the new public health system and, where appropriate, with the NHS as well. The consultation document that we published last December on the funding and commissioning routes for public health made a proposal for that collaboration. National cancer screening services should be arranged by the NHS commissioning board, while local authorities should take responsibility for behavioural and cancer awareness campaigns, and encourage early diagnosis and treatment. We await the responses to the consultation with interest.
Amendment 131 would lengthen the list of examples further, to include risks to health arising from employment—for example, risks that local authorities can minimise. Again, the amendment is superfluous.

Clause 8 already allows local authorities to take appropriate steps to address health risks arising from people’s employment, if they decide that is appropriate. I observe that, by and large, employment is good for health, and we expect employers, too, to exercise their legal duty to reduce risks to their employees’ health.

Amendment 130 is different from amendments 29, 129 and 131 in that it would change the effect of the Bill. Unfortunately, in our view, it would do so in a damaging way. It removes the provision of financial incentives from the list of example steps. Given the financial nature of such steps, the effect would be to prevent local authorities from providing incentives under the health improvement duty set out in the clause. We are not saying that local authorities should make such provision, we are saying that they ought to have the possibility available to them in discharging the duty. I would like to explain that aspect of the clause more fully because I understand that the area might be of concern.

The reference to financial incentives goes beyond cash. To quote an example from the “Healthy lives, healthy people” White Paper, the Step2Get scheme awards children who walk to school instead of catching the bus with vouchers for shops, cinemas and online games. In London, it was found that for each £1 the scheme cost, £24 was saved for local authorities and Transport for London in reduced costs in managing overcrowding at bus stops and on buses. We are not evangelical about that sort of incentive schemes as the evidence for the effectiveness is often not strong. That is not, however, a reason for the law to rule out their use altogether, as evidence may emerge later to make them a stronger case.

Local directors of public health may consider evidence together with the needs of their population. If they decide that it is appropriate to provide a financial incentive, Parliament should not take that option away. Paragraph 3(d) will allow that flexibility and evidence-based innovation, so it should not be removed. I would argue that the more examples included in the list in clause 8, the more likely it is that it would be wrongly perceived as a prescriptive list. Although amendment 130 would not add to the list, it would make the list more restrictive, which is not what we or local authorities want from the Bill. The clause will create a duty to take appropriate steps and ultimately, it is for local authorities to decide what is appropriate on the basis of reasonable advice and taking into account their population’s needs. Therefore, I hope that the hon. Lady, who is probing in the areas, will withdraw her amendments. Otherwise, I will ask my colleagues to oppose them.

Emily Thornberry: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 27, in clause 8, page 5, line 28, at end insert—

‘(4A) Where these functions are exercised by a county council, the county council shall consult any relevant district councils in its area about how best to exercise its functions under this part of the Act.’.
Health and well-being boards, which we will come to later in the Bill but which are relevant to the amendments, will play a big part in local health improvement activity, because they will bring all the relevant parts into a collaborative relationship, to commission not just health, but public health and social care. District councils can be involved via that route, regardless of whether there is the statutory duty that the amendment seeks. The clause provides a clear and workable framework for local government, and the amendments would confuse that and not help local government to discharge its responsibility. The amendments should, therefore, be withdrawn, and if they are not, I ask my colleagues to oppose them.

Emily Thornberry: Having listened carefully to the Minister, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 26, in clause 8, page 5, line 35, at end add—

'(6) In exercising these functions the Secretary of State and local authorities must consult relevant local Directors of Public Health and the Chief Medical Officer and have regard to their advice."

Independent medical input from public health specialists is important, and the British Medical Association believes that given the health expertise of the chief medical officer and the local directors of public health, there must be a statutory duty for both the Secretary of State and local authorities to consult them on public health matters. It seems self-evident that if experts are on hand, they should be consulted and, to ensure that that happens, the provision should be in the Bill.

Health protection and improvements and health care commissioning cannot be undertaken without the specialist knowledge and skills of public health professionals. Such professionals provide many specialist skills. They can assess a population’s health and well-being, and consider how needs can best be met using evidence-based interventions. They can support commissioners in developing evidence-based care pathways, service specifications and quality indicators, and can provide a legitimate context for setting priorities, using comparative effectiveness approaches and public engagement within an overall cash-limited system. They can provide advocacy for vulnerable groups, and focus on equity and accessibility, and can provide knowledge of behavioural science to underpin health improvement initiatives. They can also provide assessments of risk, and surveillance, prevention and management of communicable diseases, and can provide health intelligence to identify trends in incidence, prevalence and survival rates, as well as in the quality and outcomes of services and interventions. They can undertake health impact assessments and health equity orders, provide quality assurance of public health programmes such as screening and immunisation, and they recognise the health implications of decisions in other fields. They are experts, and they should be consulted.

Paul Burstow: I did not hear from the hon. Lady any evidence to suggest that despite the absence of a general duty to consult, the Secretary of State does not consult with the chief medical officer, and local authorities or primary care trusts do not consult with directors of public health. I do not think that the evidence is there to support the notion that the very important expertise that those specialists bring to the processes is not an essential ingredient in making appropriate decisions.

Emily Thornberry: It sits ill in the mouth of the hon. Gentleman to pray in aid the status quo, since that is what he is trying to change. The system might work at the moment, but if we are going to change it, let us ensure that we take away at least one of the many risks that the Minister indulges in by changing the whole system. [Interruption.]

Paul Burstow: I absolutely agree with what the Minister of State, Department of Health, my right hon. Friend the Member for Chelmsford said, but I will not repeat it for the record.

Let me just directly address the amendment. There has been an absence of a general duty in the past and changes are being made to the architecture, with the Secretary of State and local authorities having clear duties in the Bill. I do not find anything convincing in the notion that that should suddenly trigger the need to have a clear duty to consult with the very expertise that will be essential in the discharge of those duties.

The amendment would weigh down the public health system with another unnecessary legislative requirement to consult itself when we would reasonably expect common sense to prevail. The amendment requires both local authorities and the Secretary of State to consult the chief medical officer, who is a member of the Secretary of State’s Department, and who directs public health.

The hon. Lady set out, quite rightly, the expertise that public health professionals bring. The Secretary of State does, of course, take advice from the chief medical officer and has regard to that advice on a regular and informal basis. To require him in law to consult a senior member of his own Department is, at best, superfluous. It is unclear to me the circumstances in which the amendment would require local authorities to consult with the chief medical officer, or indeed why. It is also not always appropriate for the Secretary of State to consult with local directors of public health before acting to improve public health. We expect appropriate consultation to occur naturally and the Bill, as drafted, allows for that. Amendment 23 risks making the whole system unwieldy and slow, and is therefore unnecessary and unhelpful. I hope the hon. Lady will consider withdrawing it. If not, I urge my hon. Friends to oppose it.

Emily Thornberry: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 8 ordered to stand part of the Bill.

Clause 9

DUTIES OF CONSORTIA AS TO COMMISSIONING CERTAIN HEALTH SERVICES

Grahame M. Morris: I beg to move amendment 68, in clause 9, page 6, line 4, at end insert

`, reside in the area covered by the consortium or are visiting the area.`

The Chair: With this it will be convenient to discuss the following: Government amendment 4.
Amendment 69, in clause 9, page 6, line 8, at end insert ‘including persons living in the area covered by the relevant Health and Wellbeing strategy’.

Grahame M. Morris: Clause 9 focuses on the duty placed on consortia in commissioning certain health services, in particular it sets out which persons consortia have responsibilities to provide services for. Our amendments seek to establish that commissioning consortia have a duty placed upon them to take account of the wider population for the services they provide. We have an obligation to all sections of society. I am not just talking about homeless people, people with drug and alcohol-related problems, or indeed the travelling communities. They are important groups for whom we need to provide services, but there are also a number of other groups, such as people who work away. For example, contract workers, who might even be working away in Libya, cannot access their services and do not have any need to. They will, however, need to access those services when they return home and they may not be registered.

The NHS has always carried with it an expectation that people can access health services, which are considered to be universally available, wherever they reside and wherever they visit within the UK. Students are often encouraged to sign up with their local GP practice when they are away at university. However, I know from my own children’s experience that that often does not happen. That does not mean that students should be denied access to the health services that the Bill asks consortia to commission.

The wider question, however, is how people who live and perhaps work in more than one location will fit into the wider system envisaged in the Bill. Just as students might fall into the remit of different practices at their parental home, at their home in term time and on campus, many other people will too.

Tom Blenkinsop: My hon. Friend is making an excellent point. It is not just students who will fall into that bracket; expatriates, pensioners living abroad, seasonal employees and workers—especially the low-paid—and armed service personnel will as well.

Grahame M. Morris: Those are excellent examples, and I thank my hon. Friend for them. Another example is Members of Parliament. The situation will apply to hundreds of thousands of people across the country. In the Opposition’s view, it is essential that the Government should clarify how they intend to implement regulations under proposed new subsection (1B) dealing with anyone not registered with a GP, or who reside in the area covered by the consortia or who are visiting that area. Amendment 69 would link those responsibilities to commissioning consortia to provide us with an opportunity to bring together the strengths of NHS commissioning with the much wider influence that the local government has over a defined population.

Amendment 68 is an expectation for local authorities and commissioning consortia to work together. It would seem sensible for other areas of the Bill we have argued for a more co-ordinated and co-operative approach. I can see there is an expectation for local authorities and commissioning consortia to work together. It would seem sensible for
each—not just the health and well-being boards but the consortia—to have responsibility for all people within their prescribed boundaries at a given time, working together on prevention and commissioning.

In February last year the independent report to the then Health Secretary, entitled “Enabling effective delivery of health and well-being”, concluded that to achieve better outcomes “strong PCT and local authority partnerships” were essential. As GP consortia are to replace the PCTs, it seems sensible that a stronger link between the new health and well-being boards and the commissioning consortia should form part of the Bill.

It is also important to consider the practicalities that were referred to by the hon. Member for Central Suffolk and North Ipswich. How in practice would it work? Who would be included and excluded from commissioned services? Would it even be possible to create the system, bearing in mind what happens at the moment, where commissioned services will be used only by a prescribed group of registered patients, and considering the extent of services being commissioned? We know that 80% of services are going to be commissioned by GP consortia.

The principle that we apply of free universal care raises a number of questions about a credibility gap, which I hope the Minister can answer. For example, there is the matter raised by the Minister of State, Department of Health, his right hon. Friend the Member for Chelmsford about commissioning consortia having a duty to commission A and E and ambulance services. As we know, at the moment, anyone can be admitted to an A and E hospital or call an ambulance. How would one restrict the availability of such a service in practice to only registered persons? [Interruption.] The Minister says they are not going to do that. In that case, it is important that it is explicit in the Bill.

The Chair: Order. The Minister did not say that, because the Chairman heard him. If the Chairman had heard him say that, he would have told him he was out of order.

Grahame M. Morris: It is important that these changes are spelled out. They need to be more explicit in the Bill.

There are a few more points to which the Minister might wish to respond; he did not respond to many of the others I made. On a point of clarity, prior to the Bill reaching Report stage, we should know the persons on whose behalf the consortia are to have responsibility to commission services. What is the prescribed group? Additionally, Parliament is legislating for the future of the national health service, and every member of the Committee, irrespective of political party, will want to know that no one will fall between two stools into gaps in the health service.

My final question for the Minister is about information given to the Committee by Richard Douglas, the director general of policy, strategy and finance at the Department of Health. He said in reference to management costs—mentioned also by the hon. Member for Southport—that a “very clear management cost limit will be set for GP commissioners, based on a figure per head of population.”—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 107, Q257.]

When the Department of Health refers to “head of population”, does that mean registered patients or the whole population? Will the Minister deal with that in his response?

John Pugh: The central problem has been quite well explained by the hon. Gentleman. GPs have lists, not areas. PCTs are based on areas. Although it is possible artificially to allocate to GPs an area and call that a consortium area, it is still possible to be in a consortium area and have a GP who lies outside it. Practices expect to be funded according to the number of patients they serve and they expect to be allowed to expand. Successful ones do and, as they expand, the boundaries of people included in their lists also expand.

We have a range of possibilities that need a clear solution, because they have funding implications for the bodies that fund practices, which will be the GP consortia. Could an individual be the funding responsibility of a consortium in a particular area, which, because of the changes and the way in which people move around between GPs—from the less successful to the more successful—could be an area mainly served by GPs in another consortium? Will the areas be subject to redefinition? If so, at what point? Clearly, such issues are technical; none the less they will crop up fairly early on in the new system.

An area could end up being served by two GP practices in different consortia; it will be in one consortium area but not the other. There could be a situation in which 50% of patients in a particular geographical area were served by one practice that happened to be in the consortium and also by another practice that happened to be outside the consortium. The truth is that there will never be an exact fit unless we alter the rules of the game between GP lists and consortia areas. That creates some complications. The hon. Gentleman asked what would happen if a person had an accident in one consortium area, but happened to be the patient in a different area. What happens now is that the PCT area in which the person had the accident picks up the bill. Obviously, the ambulance service can be tweaked to do things differently, but it has severe cost implications.

Grahame M. Morris: That is an important point, and it was well made. My argument was not so much in respect of someone who is registered with a particular GP consortium or, at the moment, practice, living in Kent and having an accident in London. I fully appreciate that the bill would go now to the person’s own PCT, and to the GP consortium under the new arrangements, but what happens if the person is a student, a serviceman or someone working away, rather than one of the prescribed groups, and, for some reason, is not registered with any of the consortia?

John Pugh: At present, if any of us falls over or gets run over outside here, the burden falls on Westminster PCT. There are unfortunate PCTs that overlap dangerous bits of motorway and take up more than their fair share of cost. It must be acknowledged that there are a lot of problems. The problems are probably worst in areas such as London, where there are a lot of choices available to people. There could be a consortium area peppered with people who are served by GPs from other consortia, who in turn may make regular use of ambulances in a
non-emergency context. If that is going to be done effectively, there must be a set of principles that make it clear how we will sort out these boundary disputes, which ultimately are also funding disputes.

There will also have to be a substantial change in ambulance service IT. As I understand it, the very expensive and somewhat successful IT that the ambulance service uses at the moment is based around postcodes, and all the software will need to be rewritten if we are going to do things differently. So, in a sense we are doomed to go down that particular path so that we do not inconvenience the ambulance service too much. If we have moved towards a situation where we have an area for a GP but we also have a list that might go beyond that area, potentially we will have a set of boundary disputes and funding disputes that can be resolved only by having a clear set of principles. At the moment, I do not know what that set of principles would look like.

Mr Burns: We have had a very interesting debate. First, I want to address amendments 68 and 69, before I speak to Government amendment 4.

Amendment 68 seeks to expand the current definition in the Bill of those persons for whom a commissioning consortium will have responsibility, to include those who live in the area of a consortium or those who are visiting the area. Amendment 69 seeks to specify in the proposed regulations that the persons for whom the consortium will have responsibility could include “persons living in the area covered by the relevant health and well-being strategy.”

These amendments are unnecessary. Under new subsection 1A to section 3 of the National Health Service Act 2006, consortia will be responsible “for persons who are provided with primary medical services by a member of the consortium.”

That is the registered population. Under new subsection 1B, regulations may already allow for a consortium to be assigned responsibility “(whether generally or in relation to a prescribed service or facility) for persons who have a prescribed connection with the consortium’s area.”

That could include people who live within the consortium’s area and who are not registered with any GP’s practice, or people who are present within the area and need emergency care. We have provided for that in regulations rather than in the Bill itself to set out clearly the details specifying which consortium will be responsible for providing services for which groups of people.

In addition, as part of our system-wide approach, our proposals will create a commissioning landscape where the activities of health, social care and public health commissioners will be aligned to meet identified population needs through the development of joint health and well-being strategies. The Bill will give local government a new role in promoting integrated working between health and social care commissioners, and both the NHS commissioning board and GP consortia will have duties to support that activity.

Logically, we have provided for that in the Bill. Clauses 176 and 177 amend the Local Government and Public Involvement in Health Act 2007. Clause 176 amends section 116, so that the responsible local authority and each of its partner commissioning consortia have a duty to prepare a joint strategic needs assessment. Clause 177 introduces new sections 116A and 116B into the Act. New section 116A provides that the responsible local authority and each of its partner commissioning consortia must prepare a strategy—the joint health and well-being strategy—for meeting the needs identified in the joint strategy needs assessment. Under section 116B, consortia must have regard to the joint strategic needs assessment and the joint health and well-being strategy when carrying out relevant functions. Functions are relevant if they could be exercised “in a way that meets, or affects, to a significant extent a need included” in the joint strategic needs assessment. Under these new arrangements, we have already adequately imposed duties on commissioning consortia in relation to the persons prescribed in the amendments.

6.30 pm

The hon. Member for Easington raised a number of points that I would like to deal with in a piecemeal fashion. He raised the question of management costs, and whether the registered or unregistered population would be the basis for assessing those costs.

I can tell the hon. Gentleman that both the registered and unregistered populations will be taken into account when settling locations. He asked why we cannot accept amendment 69, given that consortia have responsibility for a given area. As I told the hon. Gentleman earlier—I will now put it in slightly blunter terms—although he believes that it would work, I do not believe that it is the most satisfactory way to proceed. The health and well-being strategy area could cover more than one consortium.

The amendment assumes coterminosity of boundaries with local authorities, but that may not be the case due to the flexibility that we are allowing consortia in terms of size and member practices.

The hon. Gentleman asked about students, and I can reassure him on that point because I do not think that there is the potential problem that he suggests. This is a classic example of where the regulation-making power is needed. Students who have temporary residence are a good example of people with a prescribed connection to the area, who will be dealt with through the regulations. I hope that that has dealt with the hon. Gentleman’s concerns.

I move on to Government amendment 4. As currently drafted, the regulation power introduced by proposed new section 1B allows a consortium to be assigned responsibility for persons who have a specified connection with the area of the consortium. The intention is that such connections could include people who live within the area and are not registered with any GP practice, as well as people present in the area who need emergency care. However, it has become clear that that would not provide for a situation where a person has registered with a GP practice but has never lived within the area of the consortium of which that practice is a member. Without amendment, that would prevent the proper operation of the current policy for NHS continuing health care arrangements.

NHS continuing health care is a package of health and personal care, inclusive of accommodation costs, that is arranged and funded solely by the NHS for people who have been assessed as having a primary health need. It can be provided in a range of settings such as care homes, patients’ homes or hospitals.
Continuing care is a complex and highly sensitive area that can affect people at a very vulnerable stage in their lives. It requires commissioning responsibility to rest with the original consortium—for example, in situations where the patient has moved home and since registered at a different practice within another consortium. That will provide continuity of care arrangements, which is in the interest of the patient.

The solution is to widen the scope of the regulation to allow consortia commissioning responsibilities to be determined either by reference to area or to practice registration, both current or previous. I hope that Government amendment 4 will be accepted by the Committee and, for reasons that I outlined in earlier remarks, that amendments 68 and 69 will be rejected.

Grahame M. Morris: I am not opposed to Government amendment 4 in principle, but I would like to respond to some of the issues raised by the Minister about coterminosity with the GP consortia practices. If GP consortia are not coterminous with local authority areas, that throws up a whole set of other problems.

That is particularly true in relation to the chestnut, raised on several occasions, of developing integrated care pathways between primary and secondary care, and the difficulties that that causes—not least over discharge and continuing health care arrangements if the hospital or consortium is in a different area from the local authority. By resolving one set of issues, it throws up a whole set of other problems as an unintended consequence. I should like to press the amendment to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 11.

Division No. 16]

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Question accordingly negatived.

Amendment made: 4, in clause 9, page 6, line 7, after ‘who’, insert ‘—

(a) were provided with primary medical services by a person who is or was a member of the consortium, or

(b) ‘—(Mr Burns.)

Grahame M. Morris: I beg to move amendment 70, in clause 9, page 6, line 16, at end insert—

‘(A) In exercising their duties under this section consortia must act with regard to the relevant Joint Strategic Needs Assessments and Health and Wellbeing strategies.’.

The Chair: With this it will be convenient to discuss the following: amendment 72, in clause 10, page 6, line 31, at end insert—

‘(c) in exercising its powers under (a) and (b) the consortium must take into account the NHS Constitution and the appropriate Joint Strategic Needs Assessments.’.

Amendment 73, in clause 10, page 6, line 36, at end insert—

‘(4) In exercising their functions under this part of the Act commissioning consortia shall have regard to relevant Joint Strategic Needs Assessments and relevant Health and Wellbeing strategies approved by relevant Health and Wellbeing boards.’.

Grahame M. Morris: Amendment 70 would strengthen the duties placed on a commissioning consortium in regard to those to whom it provides services. In the debate on the previous amendment, we discussed at length who a consortium should provide services to. I want to turn to the duties placed on it when it provides those services. In particular, we want to strengthen the role of the health and well-being boards, the strategic needs assessment, the joint health and well-being strategy and the role of the NHS constitution.

Further on in the Bill, as the Minister mentioned in the previous debate, clauses 176 to 183 set out the new arrangements for conducting joint strategic needs assessments and establishing health and well-being boards, which will also able to develop strategies, as laid out in the Bill. The production of JSNAs is a statutory duty performed by the PCTs and local authorities together. Under the new arrangements, the PCT’s responsibility will transfer to the new GP consortia structures, which will work with local authorities to develop the JSNA.

We heard from the Minister earlier that a duty will be placed on local authorities and commissioning consortia to produce a joint health and well-being strategy to meet the needs identified in the JSNA. However, those strategies should contain what I would hope to be a comprehensive set of duties that will support some of the sort of co-ordination between preventive measures taken by the local authority, which we discussed earlier, and the commissioning practices of the consortium.

Although we were assured that there would be a statutory duty to have regard to the JSNA and that the local authority and commissioning consortia would have a duty to consider—just to consider—how best to use their budgets co-operatively, we would like that responsibility to be strengthened. In particular, as part of deciding which services commissioning consortia provide, to whom they provide them and, where amendment 72 applies, which preventative, diagnostic or treatment services they provide, it is important that they be duty-bound to follow the agreed strategies. The House of Commons research paper on the Bill states:

“Clause 179 imposes a duty on the HWB to encourage integrated working between commissioners… public health and social care. Clause 180 requires HWBs to lead on the joint strategic needs assessment…and joint health and wellbeing strategy”.

However, I would like to know where the stick is for the boards to bring a consortium into line if it fails to adhere to the agreed strategy. Perhaps the Minister could aid me, because I fail to understand why there is such a lack of responsibility in respect of the protagonists in the health service—the people who hold the budgets...
and commission the service. Don Redding, the policy consultant for National Voices, said in evidence that the boards were not pivotal, but “another useful piece of the system.”

Most tellingly, he described the commissioning consortia and the commissioning board as, “the seat of power” as they were the ones “making their decisions about how to commission services and how those services will be designed.” —[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 113, Q272.]

As it stands, the Bill does not set out enough checks and balances to promote better, fairer co-ordinated services.

In our first evidence session, Sir David Nicholson, chief executive of the NHS, talked about accountability functions and, specifically, the benefits of how the health and well-being boards would hold foundation trusts to account. The Bill needs to strengthen the accountability of commissioners in the same fashion. Sir David went on to argue that the involvement of representatives from public health, GP consortia and the commissioning board would “significantly enhance the ability of the health and well-being boards to play a proper role in health care in the future.” —[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 13, Q26.]

If that is the Government’s intention, all we are asking for is greater accountability to be placed on commissioners with regard to the strategies that have been agreed. Our amendments would compel a consortium to take account of the NHS constitution and the relevant JSNA.

I would like to ask the Minister about the role of the NHS constitution under the arrangements in the Bill. An article in “Health Insurance & Protection Magazine” on 18 February reported that Sir David Nicholson had written to the NHS regarding misunderstandings about the Government’s intentions on waiting times. It says that the NHS will maintain the maximum waiting times—18 weeks—and uphold patients’ rights, as set out in the NHS constitution. Will the Minister confirm that the NHS will maintain the maximum waiting times—and uphold patients’ rights, as set out in the NHS constitution. Will the Minister confirm that the NHS constitution under the arrangements in the Bill.

My understanding is that, since then, the number of patients waiting more than 18 weeks for hospital admission has risen by more than 26,000, or 12%. As the 18-week target remains a patient right under the NHS constitution, which the Minister says he does not intend to remove, can the Minister explain why that legislation is being ignored by his Department? Will it be kept under the new arrangements? If the constitution is staying, perhaps the Minister will be able to support amendment 72.

From the explanatory notes to the Bill, I understand that clause 233 provides that NICE would have a duty to have regard to the NHS constitution. However, there would only be a “continuation of certain rights in the NHS constitution” in relation to the commissioning board and consortia. Those “certain rights” would be underpinned by regulations instead. Will the Minister clarify what those rights would be?

Mr Burns: Amendment 70 seeks to make it explicit that consortia, in exercising their duties to commission services, must act with regard to the relevant joint strategic needs assessment and health and well-being strategies. I must tell the hon. Gentleman that that is already covered in the Bill.

Clause 177 inserts proposed new section 116B into the Local Government and Public Involvement in Health Act 2007, which imposes a duty on consortia to have regard to the most recent joint strategic needs assessment and joint health and well-being strategy when exercising relevant functions.

Proposed new section 14Y(1), which is inserted into the National Health Service Act 2006 by clause 22, states: “Before the start of each financial year, each... consortium must prepare a commissioning plan setting out how it proposes to exercise its functions in that year.”

Proposed new section 14Y(3) requires the commissioning consortium to consult the health and well-being board “about its views on whether the plan takes proper account of the most recent joint health and wellbeing strategy”. Proposed new section 14Y(4) provides that the health and well-being board “must give the consortium its opinion on whether its commissioning plan takes proper account of the most recent health and wellbeing strategy, and that the consortium must include a statement of the Health and Wellbeing Board’s opinion in the plan.”

The joint strategic needs assessment, which must be prepared by the responsible local authority and each of its partner commissioning consortia through the health and well-being board, will inform the joint health and well-being strategy, which will be a strategy for meeting the needs of the JSNA. Amendment 72 looks to make explicit in clause 10 that consortia, in exercising their powers to arrange provision of such services or facilities as they consider appropriate to secure improvements “in the physical and mental health of the persons for whom it has responsibility” and
“in the prevention, diagnosis and treatment of illness in those persons”.

must take into account the NHS constitution and appropriate JSNAs. Amendment 73 seeks to make explicit that consortia, in exercising their powers to commission certain health services, must have regard to the relevant JSNAs and relevant health and well-being strategies.

Members of the Committee must understand that the amendments are already covered in the Bill, and it may be helpful if I explain why and how.

Paragraphs 74 and 75 of schedule 5 will amend section 2 of the Health Act 2009 such that the NHS commissioning board and commissioning consortia will have to have regard to the NHS constitution in the performance of all of their functions. Local authorities and commissioning consortia will be required to undertake the JSNA through the health and well-being board. That will ensure that each area develops a comprehensive analysis of its current and future needs. That will include health and social care, and it will possibly involve an analysis of the commissioning of services covering the wider determinants of health and how that could be more closely integrated with local health and social care commissioning.

Local authorities and commissioning consortia, through the health and well-being boards, will also have to prepare a joint health and well-being strategy for meeting the needs identified in the JSNA. Clauses 176 and 177 amend the Local Government and Public Involvement in Health Act 2007 to enable that to happen.

Clause 176 amends section 116 of the 2007 Act so that the responsible local authority and each of its partner commissioning consortia has a duty to prepare a JSNA. Clause 177 inserts new sections 116A and 116B into the 2007 Act.

New section 116A provides that the responsible local authority and each of its partner commissioning consortia must prepare a joint health and well-being strategy for meeting the needs identified in the JSNA. Under new section 116B, consortia must have regard to the JSNA and the joint health and well-being strategy when carrying out their relevant functions. Functions are relevant if they could be exercised in a way that meets or affects to a significant extent a need included in the JSNA.

As I have mentioned, new section 14Y establishes a duty on the commissioning consortium to consult the health and well-being board on whether it thinks the commissioning plan takes proper account of the most recent joint health and well-being strategy. The consortium must include a statement on the board’s opinion in the plan. With those new arrangements, I believe we have adequately provided for the concerns raised in the hon. Gentleman’s amendments.

The hon. Gentleman also asked about NICE and the NHS constitution. He asked why consortia were not included. Clause 123 introduces schedule 16, which includes provision for the constitution to apply to NICE. As I have already said, the change for consortia is made by schedule 5 to the Bill.

With that comprehensive explanation of why we do not need the amendments, I trust that the hon. Gentleman will feel that he can withdraw his amendment.

Grahame M. Morris: I thank the Minister for his comments on the JSNA and the joint health and well-being strategies, which I have noted. I fear for the long-term health of the NHS constitution if the Government do not accept amendment 72. I recognise the time constraints, however. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.
Clause 9, as amended, ordered to stand part of the Bill.

Clause 10

POWER OF CONSORIA AS TO COMMISSIONING CERTAIN HEALTH SERVICES

Liz Kendall: I rise to speak to amendment 71, which would strengthen a requirement on commissioning consortia. The Bill states:

“Each commissioning consortium may arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement in the physical and mental health of the persons for whom it has responsibility, or in the prevention, diagnosis and treatment of illness in those persons.”

The amendment would replace “may” with “must”, but as we have had that debate several times already, and in the interest of moving more swiftly on to an important group of proposed amendments to clause 11, I will not move the amendment.

Clause 10 ordered to stand part of the Bill.

Clause 11

POWER TO REQUIRE BOARD TO COMMISSION CERTAIN HEALTH SERVICES

Liz Kendall: I beg to move amendment 74, in clause 11, page 7, leave out line 7.

The Chair: With this it will be convenient to discuss the following: amendment 108, in clause 11, page 7, line 9, at end add ‘and Armed Forces veterans’.

Amendment 109, in clause 11, page 7, line 12, leave out ‘may be prescribed’ and insert ‘set out in the Specialised Services National Definitions Set.’.

Liz Kendall: Clause 11 is important because it gives the Secretary of State the power to require the national NHS commissioning board to commission certain services. Amendments 74, 108 and 109 explore the rationale and processes for defining which services are best commissioned at national level.

Amendment 74 is a probing amendment relating to dental services. Clause 11 states that the national commissioning board will commission “dental services of a prescribed description”.

In other words, it shifts responsibility for commissioning dental services from local primary care trusts to the national board. The amendment would delete the reference to dental services—not, I emphasise, because we think that should be the case, but because we want to explore the matter.

First, we are concerned that the Bill does not make it clear where responsibility for commissioning all types of dental services will rest. Secondly, as a constituency MP, I have concerns about whether a national board will know what services to commission in my constituency. Primary care trusts, although not my own, have sometimes struggled to determine precisely the type and nature of dental services required at the very local level where
there are particular needs. That is an important question, as is the first about the lack of clarity on where responsibility for commissioning all types of dental services will rest.

There are three types of dental services. First, there are general dental services, which include family dentists—I hope all members of the Committee are registered with one. Secondly, there are salaried dental services, also known as community dentistry for vulnerable groups. Thirdly, we have hospital dental services for people with specialised needs, sometimes relating to—I do not know the exact terminology—throat and mouth diseases and cancers affecting the head; those are linked to hospital services.

Earl Howe recently confirmed in the other place that the NHS commissioning board will commission secondary dental care in England to ensure “consistency of approach”, because there was concern about who would do that. However, doubt remains about where responsibility for commissioning community dentistry lies. That question has been raised with many hon. Members by the British Dental Association.

Salaried dentists provide a wide range of services for vulnerable or otherwise disadvantaged groups, who may find it difficult to attend family dental practices. For example, salaried dentists provide dental care for the homeless and for people in prison and in care homes. They also have a role to play in non-treatment, if that is an accurate phrase—in other words, oral health promotion and outreach teaching. The BDA has said that, because of the dynamic and complementary nature of the relationship between salaried and general dental practice, it is essential that those services are commissioned by the same commissioner, to ensure that there is no duplication of service and, more important, no gaps in provision. Will the Minister clarify whether the national NHS commissioning board will commission community dental services?

Mr Burns: The straightforward answer is yes.

7 pm

Liz Kendall: I am very glad that we now have that on the record. I am sure that that will be of real help to dentists, their board and others.

My second concern is whether the national board will have the local expertise, knowledge and understanding that vital to meeting local needs. We have yet to hear how the regional and local structures of the board will be determined. Again, the BDA has raised a number of questions which I should like to put to the Minister.

First, how will the Government ensure that the national board has the local knowledge and understanding needed genuinely to meet people's needs? In New Parks, a very deprived area in my constituency, one of the local dentists has been working with the PCT with a view to expanding his services. How will that happen if dentistry is commissioned at that national level?

Secondly, will local dental committees be involved in the commissioning process and if so, how? Currently local dental committees liaise with PCTs. Will local authorities be required to consult with local dental committees as part of the health and well-being strategies?

Public oral health is an important indicator of wider health outcomes and linked to some of the underlying determinants of health. Thirdly, what will be the role of consultants in public dental health who also have an important role to play in improving the dental health of local populations?

Amendment 108 would add a reference to armed forces veterans. The clause says that the commissioning board will commission health care for the armed forces. This is a probing amendment to see whether it will also cover care for veterans. My understanding of the Bill is that health care for members of the armed forces will be commissioned by the board, but when they leave the forces their health care will be commissioned by commissioning consortia. How will the Minister guarantee a smooth transition from the national commissioning board having a role to when people leave the armed forces and may need continuing care, including for mental as well as physical health issues? How do we ensure that there is no change in the consistency or quality of care?

I am sure that I do not need to tell the Committee that there are 5 million veterans in England. For the vast majority, their time in the service will have been a positive experience, but many leave with physical and mental health conditions for which effective commissioning is needed. With the ongoing deployment of UK forces, it is more important than ever that the NHS works closely with the military services to ensure that the health needs of those in the armed forces, veterans and their families are properly met.

Amendment 109 probes the other kind of services that will be commissioned by the national commissioning board. It aims to clarify that “such other services or facilities” will include all those that are currently included in the specialised services national definition set. That set has been chosen because it outlines all the specialised services that the centre currently commissions. Specialised services are defined in law as those services with a planning population of less than 1 million, and typically a specialised service is one that is provided by fewer than 50 hospitals nationally. The specialised services national definitions set lists 38 different types of service, including cancer services, blood and marrow services, spinal services, cystic fibrosis services, renal services, services for those with liver and pancreas problems, and medical genetic services.

Yesterday, I attended the Rare Disease UK and Genetic Alliance UK event held to highlight rare disease. The people who attended that event would like reassurance that all those specialised services will be commissioned nationally. That has not been specified and set out. Even though the services are specialised, there is an awful lot of people who want that reassurance, so I hope that the Minister will clarify the matter.

Mr Barron: My hon. Friend says the amendment was tabled to probe the Government on arrangements for national health service dentistry in this country, but in my view the amendment ought to be carried. During the first sitting of this Committee, we heard the chief executive of the NHS talk about where NHS dentistry in this country will be commissioned after the Bill is enacted. He said that, in relation to dentistry, that had not been worked out. I read him a quote from the British Dental Association, which is confused about the position, as my hon. Friend has said, and asked him:
Mr Barron: 

"Given the history of NHS dental services in the past 10 years, are you sure that a national commissioning board is the right and proper way to do this?"—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 15, Q32.]

I was on the Select Committee on Health in the previous Parliament—I do not think that the Minister was on it at that time. The reason why I posed that question was that that Committee carried out an inquiry into NHS dentistry and found that it had been going out of fashion in many regions of England, primarily because money—private insurance—had come on to the scene. Some dentists were wrongly—we took evidence on this—saying to people, "You take out private insurance to cover your health needs and I will treat your children on the national health service." That is well known—it was evidence taken in public.

The Health Committee had a running battle with the Government—my Government, I have to say—who were in denial about the state that NHS dentistry had got into. Eventually, when we brought Ministers back into Westminster Hall for a debate, their immediate response to that report on NHS dentistry was that the situation was wrong. They set up a committee to look at the situation and they started to bring NHS dentistry back into those parts of the UK from which it had gone for the reasons that I have described.

That is the truth about what happened to NHS dentistry. I can understand it to some extent. I rarely go to the dentist without paying money. I do not always have a clinical need; the treatment is sometimes cosmetic, and the cost of that should not be met by the NHS, but clinical need costs should be. Some people are not able to pay as I and many others do, but they need NHS dental, clinical services. My great fear is that in the Bill we are taking a step that will knock back NHS dentistry, which is not in a brilliant position now, although it is better than it was.

I happened to see my dentist for a check-up on Saturday morning. When I asked her what she thought about the new commissioning of services, she laughed. She is a very serious dentist—she came and gave evidence to that Health Committee inquiry. Now, I have a lot of time for Sir David Nicholson—there is probably nobody in the UK who is more knowledgeable about our health service and all its intricacies—but when I asked him whether he was sure that this was the proper way to do it, he replied:

"It is what has been set out in the legislation. That connection between local and national is going to be critical to its success. There are different ways to define national and local. There will be a national contract of sorts, I guess, quite different from the one we have at the moment. There will be a local interpretation of that in individual circumstances. How is that to be done? It could be through PCTs, through the national commissioning body, through a whole set of things, but that principle about national and local applies."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 16, Q32.]

I greatly admire Sir David Nicholson, but I do not understand what he means, and I do not think that he knows either, because this is the most ill thought out part of the legislation. There might be an argument for national commissioning in relation to orthodontists—normally, not just one but several PCTs got together for orthodontist services—but in all my years in Parliament I have never seen such a foolish provision as we have in this Bill. It is most foolish to think that we can nationally commission local NHS dental services. It flies in the face of the history of the NHS over the past 10 years, when we have been putting NHS dentistry back together in areas where it had gone out of fashion.

I say to the Committee, we ought to carry the amendment and take dental provision out of the hands of the national commissioning board and put it back into the hands of local commissioners—GP consortia or similar—that can really look at and meet the needs of individual areas of the UK.

Mr Burns: As the hon. Member for Leicester West said, this is a probing amendment. I have confirmed that the commissioning of dental services will be done by the national commissioning board. She asked what the role of local dental committees will be. They will continue to have a role whereby the national commissioning board will be able to draw and benefit from their expertise in its endeavours to deal with commissioning. She also asked how else they will keep in touch with local needs. I will deal with that as I develop my remarks.

I note the comments of the right hon. Member for Rother Valley—particularly in the light of his experience of looking at dentistry in the Select Committee on Health during the previous Parliament—but his dentist’s view, voiced last Saturday, is not shared by everyone in dentistry. For example, the Dental Schools Council has said:

"The move away from PCTs as commissioners of dental services is a positive one, opening up opportunities for co-ordinated and intelligent dental commissioning."

I am sure that the right hon. Gentleman has access to quotes as well, but the British Dental Association has also welcomed our approach, as has the Faculty of Dental Surgery. I want to put that in context, because not everyone agrees with the right hon. Gentleman’s dentist. There is considerable support for what we seek to do.

Mr Barron: I will not quote what Margaret Naylor has said, because we can look at the report to see her view of NHS dentistry. The BDA has said that it is “anxious to ensure that mechanisms are in place to strengthen the ability of commissioners and providers to develop services that are responsive to local needs, and to ensure that they are fully integrated with other NHS services.”

Most people would say that that should be done at GP consortia level. That is where it is brokered now. In communities in my constituency where there is NHS dentistry, the general dental units are brokered on a dentistry-by-dentistry basis to ensure that constituents have an NHS service. I cannot see how that can be delivered but at a national level.

7.15 pm

Mr Burns: I am grateful to the right hon. Gentleman for his remarks. What I was about to say before his intervention directly leads on to answer the point that he has just made. My answer on GP involvement—this is in no way a criticism of GPs—is that most general medical practitioners have little or no involvement in NHS dentistry. Most people access NHS dentistry directly through their registered dentist rather than through a
GP, which is why the majority of referrals to specialist dental services come from primary care dentists and not GPs. There is no record of knowledge or custom among GPs with regard to commissioning dental care, so it would not be an obvious place in which to put the commissioning of dental services. I favour it being done through the national commissioning board.

The way in which local needs can be addressed is through the local dental boards; the health and well-being boards that will be in all local communities; local government, because local authorities will have a responsibility as part of the input on meeting the health needs of the local community; the joint strategic needs assessments; and in certain circumstances the local healthwatch. There will be a link between national commissioning boards and local needs, and local needs will be identified as part of the commissioning process.

Mr Barron: I am grateful to the Minister for that clarification. It is quite clear that there will be a link in each community between national commissioning and delivery on the ground. Why can local dental committees not work with the local consortia group to ensure that this is done in a proper manner? If he talks to dentists at this time in the financial year, he will find that some of them are doing little work because they have earned the right amount for their contract for this financial year; others, on the other hand, will be doing two or three days a week more, or doing more work on days that they do not normally work, so that they can earn the money that is allotted to the dental practice. Dentists work to very sophisticated contracts and I cannot see how the system will work on the proposed arm’s length basis. If local dental committees are to look after the interests of local NHS dentistry, why are they not working with commissioners who are there locally as well?

Mr Burns: I have listened to what the right hon. Gentleman has said, but I fear that we are now beginning to go round in circles. I fundamentally disagree with him on this specific point. As I said earlier—I still stick by this—the experience and the involvement of general medical practitioners in the commissioning of dental care has been almost non-existent, so they are not the right people to progress this.

Dr Poulter: We all share, I think, the right hon. Gentleman’s frustration with the inadequacies of NHS dentistry. However, he fails to identify an appropriate solution. The Minister rightly points out that the access to dentistry is very different from access to GPs and medicine. The two are distinct and rarely interrelate. This Bill correctly differentiates those services.

Mr Burns: I am extremely grateful to my hon. Friend. Naturally, I agree with the tenor of his intervention, but what heartens me is that he speaks with the experience of having been a medical practitioner, so he knows a considerable amount about how commissioning has happened in the past and about providing the finest health care for patients. I am extremely grateful for his support.

I do not want to detain the Committee, so I will move on to amendment 108, which is extremely important because it deals with veterans’ health care. I agree with the hon. Member for Leicester West that it is extremely important to ensure that the health of all veterans is properly dealt with by the NHS when they are discharged from the armed forces. The health of those who have served our country is a matter of care to those who have been injured as a result of their service to ensure that their health needs are properly met when they return to civilian life.

The vast majority of veterans leave the armed forces fit and well, fortunately, having benefited from their time in the services. There are approximately 4 million veterans in England, ranging in age from those who served in the second world war or completed national service to those who are currently on the front line in Afghanistan. On discharge, they become members of their local communities and will be able to access their local NHS services on the same basis as other members of the public.

Clause 11 allows for regulations to require the NHS commissioning board to commission services for members of the armed forces or their families. That is because members of the armed forces are able to access NHS secondary care services directly on referral from Defence Medical Services, which makes demand unpredictable. Demand from members of the armed forces for those services may also vary according to tours of duty, for example, and have the potential to impact significantly on consortia budgets and commissioning strategies. We therefore think it more appropriate for the NHS commissioning board to have responsibility for arranging those services, working closely with relevant local consortia.

However, the health needs of the vast majority of veterans are very much the same as those of the wider population and are best met and commissioned on a local basis. For those who are seriously injured or who need access to mental health services—the hon. Lady mentioned that very important issue, and I suspect that there will be increasing demand on the NHS—we already have measures in place to ensure that those needs are also met locally, and we are in the process of building on them. We therefore believe the commissioning consortia, rather than the NHS commissioning board, should be the commissioners of services for veterans of the armed forces, as for other members of the public.

It is important to recognise that although the health care needs of veterans are similar to those of the majority of the population, veterans may face disadvantages when accessing services because of geographical mobility and being accommodated in poor housing within disadvantaged and often rural areas. We must ensure that we do all we can to redress the balance, so we are working on measures to help health professionals to understand the needs of veterans. To that end, we have also established armed forces networks running each SHA area to work on local troubleshooting, policy development and implementation. Specific mention of the importance of the NHS making provision for those is made in the operating framework for 2011.

Amendment 109 would remove the power for the Secretary of State to require the board to commission such other services as may be prescribed under new section 3B (1)(d) of the 2006 Act, and would instead require the commissioning board to commission only those services covered by the specialised services national definitions set. That is unnecessarily restrictive. The clause currently allows for regulations to prescribe that other services or facilities should be commissioned by
the NHS commissioning board if the Secretary of State considers it appropriate for the board, rather than consortia, to commission those, having regard to a number of factors listed in new section 3B(3). The intention is that that would include, for example, specialised services for patients with rare conditions, where regional or national commissioning arrangements currently apply because of such services’ low volume and high cost, and which are currently either commissioned nationally by NHS London, or regionally by PCTs through collaborative commissioning arrangements.

In deciding what services would be appropriate to include in regulations under new section 3B(1)(d), the Secretary of State would be required to take into account certain factors such as the number of people needing the services; the cost of providing them; the number of providers able to offer services; and the financial impact on consortia of having to commission those services. The specialised services definitions set would be our starting point in determining what would be appropriate to include under these regulations. However, it is important that the Bill allows flexibility when determining which services are best commissioned by the NHS commissioning board or by the consortia. Tying the content of the regulations to those services covered by the current version of the specialised services national definition set would reduce that flexibility. It is for those reasons that, if the hon. Lady decides to press the amendments to a vote, I ask my hon. Friends to join me in opposing them.

**Liz Kendall:** Thank you, Mr Hood, and I am grateful to the Minister for his response. I will go in reverse order to liven things up. First, in amendment 109, I am very grateful that the Minister has said that the specialised services national definitions set will be the starting point. That will be very reassuring to all the patients and patient groups covered by those conditions. However, I am concerned that clause 11 leaves it very open to the Secretary of State to determine what is a national service and what is local. I will discuss that under the next group of amendments.

Secondly, I am grateful for the Minister’s explanation regarding support, services and commissioning for veterans. He is obviously right to say that, for many veterans, their health needs become the needs of the rest of the population, but it is important that we recognise and acknowledge that truism, which is the reason I tabled the amendment.

Thirdly, and the most important, we talked about dentistry. I do not think that the Minister has adequately explained how a national commissioning board will have the understanding, skills, experience or expertise to commission local dental services. Such a board might be equipped for hospital services, but not for general dental practice or salaried dentists. I do not understand the explanation that the Minister has given, nor do I think the chief executive of the NHS understands it. It has not been thought through yet, and on that basis I would like to press the amendment to a vote.

**John Pugh:** Does the hon. Lady accept that the one thing dentists probably do not want is to be commissioned only by GPs? An elegant solution, so far uncavassed, which might lead to a meeting of minds between the right hon. Member for Rother Valley and the Minister, would be a local clinical commissioning body that was not exclusively made up of GPs.

**Liz Kendall:** The hon. Member for Southport will know that Opposition Members have very much agreed with some of his comments about reforming PCTs as they currently are, rather than changing all of this and giving everything to GPs who may not have knowledge of dentistry, or indeed of specialised counsellor services, mental health, and a whole range of other things. Unfortunately, we are considering where his party’s coalition Government stands on this Bill, and therefore I would like to press these amendments to a vote.

**Question put, That the amendment be made.**

**Division No. 17**

**AYES**

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

**NOES**

Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot

**Question accordingly negatived.**

7.30 pm

**Liz Kendall:** I beg to move amendment 75, in clause 11, page 7, line 14, leave out from second ‘the’ to end of line 16 and insert

‘provision of the service to be arranged at a national level rather than a local level’.

**The Chair:** With this it will be convenient to discuss amendment 76, in clause 11, page 7, line 25, at end insert—

‘(e) the extent to which services are provided by local providers rather than by regional or national providers’.

**Liz Kendall:** These amendments follow on from the previous set of amendments. We are trying to clarify the basis on which the Secretary of State can require the national commissioning board to commission certain types of services. The aim of the amendments is to get the Government to consider whether it is more appropriate for a service to be commissioned nationally or locally as the primary issue before they go on to consider which body should commission it. The Government are sometimes in danger of fitting the service around their proposals for commissioning rather than the health needs.

We have talked about dentistry as an example of that, and I am sure that the Minister will be enthusiastic to discuss maternity services. Initially, the Government said that those would be commissioned by the national
commissioning board. Then, following the response to the consultation relating to the White Paper, “Equity and excellence: Liberating the NHS,” they decided that they should be commissioned by GP commissioning consortia.

I am sure hon. Members know that the Royal College of Midwives says that it is “deeply disappointed that the government have performed a u-turn” on the policy expressed in the White Paper of having maternity services commissioned by the national NHS commissioning board and have instead placed them in the hands of commissioning consortia.

It is not just the RCM that is concerned about the decision or that has opposed the U-turn, but the Royal College of Obstetricians and Gynaecologists and the charity Bliss. They all backed the original proposal because they felt that the national board was better placed to deliver high-quality and equitable maternity services. The president of the RCOG, Dr Tony Falconer, said that the decision was a “missed opportunity to deliver a seamless, uniform maternity service.”

The chief executive of the National Childbirth Trust, Belinda Phipps, says:

“Our very strong view is GPs are not the right people to commission maternity services.”

She says that in fact that could be “dangerous.” The RCM’s general secretary, Professor Cathy Warwick, says:

“GPs absolutely need to be involved…but that doesn’t mean they need to be commissioning, and they are not the people with the greatest knowledge.”

I am not at this stage commenting on the decision itself; I am raising the issue of the process by which the decision was made. Many of the professional bodies and bodies representing mothers, particularly with very sick young children, are concerned that the decision was changed because of pressure from lobbying groups, particularly the GPs, and not on the basis of people’s health needs or the quality of care. I therefore ask the Minister to explain, using the example of maternity services, the basis on which the decision was taken. What was the evidence about people’s health needs, or where services were delivered and provided, whether locally, regionally or nationally? How will the Secretary of State decide which services are commissioned locally or nationally, and how will he guarantee that that is based on need, and not on the existing structures? Many people feel that it is the structures that are driving the decision, not the health needs.

Mr Burns: In discussing the amendments, the hon. Lady devoted most of her comments to picking an example and dwelling on it, and she is, of course, more than entitled to do that to illustrate her arguments. My approach will be more classical, and I will deal with what the amendments propose and why I certainly do not share Labour Members’ enthusiasm for them.

As a background to the amendments, the clause allows the Secretary of State to require the NHS commissioning board to commission certain services. Amendment 75 proposes that a service or facility should be prescribed under proposed new section 3B(1)(d) to the 2006 Act, only if the Secretary of State considers it to be appropriate for it to be commissioned at a national, rather than local, level.

Amendment 76 proposes that an additional factor that the Secretary of State should take into account, when requiring the board to commission such services or facilities, should be “the extent to which services are provided by local providers rather than regional or national providers.”

I appreciate that the intention of the amendments is to reduce the scope for certain local services to be commissioned by the board, which would instead ensure that the services are the responsibility of commissioning consortia.

I think we all agree that it is sensible for the commissioning board to lead in commissioning those services for patients with rare conditions that are high-cost and where clinical expertise needs to be concentrated, requiring the services to be commissioned and organised separately. We have just discussed the fact that the specialised services national definitions set will be our starting point in determining the services. It is, however, not as simple as saying that the services we are discussing would only be those that are provided regionally or nationally. We would then have to try to define exactly what such terms mean.

In practice, the services currently covered by the national definitions set have varied degrees of prevalence, and are therefore planned across population sizes ranging from 500,000 patients to 10 million. That is why we have included a number of factors that the Secretary of State must take into account in proposed new subsection (3). They include: the number of people requiring the service; the number of providers available to provide it; the costs involved in providing the services; and the implications for consortia of having to try and commission the services. Those points are largely based on the factors that are considered when determining what is appropriate for inclusion in the current specialised services definition set. They therefore represent a reasonable and consistent approach to deciding such matters in the future.

That is not to say that GP consortia would have no role to play in relation to the services. The commissioning board would, in practice, need to work closely with consortia in identifying the levels of need for such services around the country, developing care pathways for patients who need to access a number of different services and agreeing contracts with providers.

The board would also have powers to delegate aspects of the commissioning process to consortia, if that were the most effective solution. I believe, therefore, that the Bill already provides an effective means of determining the most appropriate level at which commissioning arrangements for such vital services should take place and it provides potential for a more effective and efficient approach in the future. For those reasons, I ask the hon. Member for Leicester West to reflect and consider withdrawing her amendments.

The hon. Lady asked why we decided that it was more appropriate for maternity services to be commissioned by consortia than by the national commissioning board. As she is aware, we published our White Paper in July and received more than 6,000 responses from members of the party—sorry, the public—[Interruption.] Well, some members of the Conservative and Liberal Democrat
parties would have responded in the same way that members of the Labour party undoubtedly responded. Members of political parties, members of the public, stakeholders, people from within the NHS and others all contributed.

Nick de Bois (Enfield North) (Con): It is perhaps worth reminding the Minister that the NHS Alliance meeting held after the White Paper was published produced a paper showing that two thirds of its GPs were outraged that that commissioning would not be done by consortia, for a good reason. They felt, among other things—obviously, maternity and primary care are important—that maternity care provided a link with primary care for many people who do not normally go to their GP. They thought that that was vital.

Mr Burns: I am grateful to my hon. Friend for drawing that valid point to the Committee’s attention. The White Paper received more than 6,000 responses, and we are prepared to listen to them. Where a viable improvement on our proposals comes up, we are prepared to change, adjust and amend our proposals. As hon. Members will be aware, the heart and core of the modernisation programme is not only putting patients at the centre of health care but raising standards to the highest level and improving and enhancing outcomes for patients. The decision was our response to the White Paper.

Many people raised concerns about making the commissioning board responsible for maternity services, advocating that they should be given to GP consortia. I point out that the board will still have a strong role in promoting quality improvement and extending choice for pregnant women, which reinforces the need for close collaboration between the NHS commissioning board and consortia. That approach is most likely to deliver improvement and a joined-up approach to local services for women and newborn children. I hope that the hon. Lady is reassured on that point.

Liz Kendall: I thank the Minister for his reply. The reason why I picked an example is that the Bill is about real people and real lives. I picked an example that affects millions of women. We can judge the Bill only by real people and real lives. I picked an example that affects millions of women. We can judge the Bill only by real people and real lives. I picked an example that affects millions of women. We can judge the Bill only by real people and real lives. I picked an example that affects millions of women. We can judge the Bill only by real people and real lives.

Mr Burns: I am fully accepting what the hon. Lady says. I was not criticising her use of that example; she is absolutely right to bring Committee proceedings to life by illustrating them with real-life examples, provided those illustrations are based on accuracy and fact.

Liz Kendall: It was indeed. Will the Minister tell me what I said that was either inaccurate or not factual?

Mr Burns: I was not referring to the hon. Lady’s example about maternity, but some of her past comments have bordered on fantasy world.

7.45 pm

Liz Kendall: I am sure that the Minister is very busy, so I will not ask him to specify an occasion when I have said anything fantastical, or at least not in this room. The Government say that they have listened to people’s concerns about this and have changed the legislation. In many other areas of the Bill, people have voiced concerns that the Government have not listened to. Regarding the amendments, people may feel that the Secretary of State can be lobbied to change his mind if a clear list of criteria and principles is not given. As the Bill stands, it will be up to the Secretary of State to issue regulations that are not discussed by Parliament, on which he does not have to consult. The intention behind the amendments was to clarify the process of deciding which services are commissioned nationally based on need, not based on the structures. I am sure that we will return to the question on Report, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

The Chair: Order. I intend to suspend the Committee for dinner, but I thought that we would squeeze this amendment in first.

Liz Kendall: I beg to move amendment 77, in clause 11, page 7, line 29, at end insert—

(c) consult with commissioning consortia and Health and Wellbeing Boards.

The amendment seeks to require that when the Secretary of State is deciding whether a national board should commission a service or whether that should be done locally, he or she should talk to local consortia and local health and well-being boards. I do not understand how a Secretary of State can decide whether a service is to be commissioned locally or nationally without consulting the very people who would be part of commissioning that service locally. It does not make sense. The amendment would help the Secretary of State in his or her decision about where services should be commissioned.

Mr Burns: I will be very quick. I appreciate that the intention of the amendment is to ensure local engagement over services that should be commissioned by the board, but the types of services that the commissioning board may be required to commission under clause 11 have been included because there are good reasons why they are more appropriately commissioned by the national commissioning board at a national level. We have discussed some of those reasons in relation to previous amendments, so I will not go over ground that we have covered.

The NHS commissioning board commissioning those services instead will allow GP consortia to focus on the services that they can directly influence, which their patients access daily. As I have already said, however, that is not to say that GP consortia would have no role to play in relation to those services. The commissioning board would, in practice, need to work closely with
consortia in identifying levels of need for these services around the country, developing care pathways for patients who need to access a number of different services and agreeing contracts with providers. The board would also have powers to delegate aspects of the commissioning process to consortia if that were the most effective solution.

The Secretary of State would be required to seek appropriate advice before making regulations under the clause, and we are currently considering how that could best be achieved. The Secretary of State would also be required to consult the board. The board itself would be required, under clause 19, to take steps to secure appropriate professional advice in discharging its functions, which would include its approach to commissioning these services. It will, therefore, be well placed to advise the Secretary of State on what the regulations should cover. Those powers will provide an essential means of ensuring the most appropriate level at which commissioning arrangements for vital services should take place, and will provide potential for a more effective and efficient approach in future.

For those reasons, I hope that the Committee will reject the amendment if the hon. Lady does not want to withdraw it.

Liz Kendall: I do not think that the Secretary of State should be able to decide through regulations, without consulting Parliament, whether the national board should have responsibility for commissioning something without his having some consultation with GP commissioning consortia or the local health and well-being boards, which would either be key to delivering that locally or may have concerns about its being delivered nationally. For that reason, I will press the amendment to a vote.

Question put, That the amendment be made.

Division No. 18

AYES
Abrahams, Debbie
Barron, Rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Thornberry, Emily
Turner, Karl
Wilson, Phil

NOES
Burns, Rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot
Lefroy, Jeremy
Poulter, Dr Daniel
Souby, Anna
Sturdy, Julian

Question accordingly negatived.
Clause 11 ordered to stand part of the Bill.
Clauses 12 and 13 ordered to stand part of the Bill.

Clause 14

Regulations as to the exercise by local authorities of certain public health functions
Amendment made: 92, in clause 14, page 11, line 9, leave out ‘protection’ and insert ‘health’.—(Paul Burstow.)
Clause 14, as amended, ordered to stand part of the Bill.
Clause 15 ordered to stand part of the Bill.
Clauses 16 to 18 ordered to stand part of the Bill.
Ordered, That further consideration be now adjourned.
—(Stephen Crabb.)

7.53 pm
Adjourned till Thursday 3 March at Nine o’clock.