CONTENTS
Written evidence reported to the House.
Clauses 19 under consideration when the Committee adjourned till this day at One o’clock.
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Monday 7 March 2011

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

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The Committee consisted of the following Members:

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

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Thursday 3 March 2011

(Morning)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 65 Royal College of Speech and Language Therapists
HS 66 Ruth Marsden
HS 67 East Riding of Yorkshire LINk
HS 68 Wendy Savage MBBCCh FRCOG MSc (Public Health) Hon DSc
HS 69 Julie Lord
HS 70 Target Ovarian Cancer
HS 71 Dr Rachel Wood
HS 72 The Hepatitis C Trust
HS 73 Adam D G Macleod

9 am

The Chair: So that there is no confusion, I should point out to hon. Members that I come from the home of Nelson, so I have a blind eye to certain things. We can leave it at that. Hon. Members will understand what I mean. I will not notice if people indulge in something other than water. Is everyone happy with that?

Hon. Members: Hear, hear!

The Chair: We shall move on, despite the Deputy Speaker's orders.

Clause 19

The NHS Commissioning Board: further provision

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 111, in clause 19, page 14, line 37, at end insert 'for approval by Parliament.'.

The amendment would also give nationally elected representatives the opportunity to say what they think the national commissioning board should be doing. An opportunity for Parliament to say that once a year, and for the board to hear what MPs had to say, would be a good thing—not something that the board, the Secretary of State or the Department of Health should be concerned about.

This is a probing amendment. The Government want to emphasise democratic accountability, and we are testing how far they want to go with that. There are questions about the accountability of the board that have already been debated, but how will Parliament hold the board to account? We are proposing a method by which we would be able to do that.

How would the board be responsible to Parliament for the performance and management of the NHS? The amendment is another vehicle by which that could be achieved. Previously, it has been the Secretary of State directly who has given instructions, but as his accountability for the management has been so seriously loosened, would it not be right for Parliament to have a greater role in holding the board to account? If the Secretary of State lets loose control of the board and the board becomes more autonomous, we ought to take every opportunity we can to hold the board to account. The amendment provides an opportunity to do so. I should like to hear the Minister's views.

The Minister of State, Department of Health (Mr Simon Burns): I noted the hon. Lady's comment that this is a probing amendment; I shall respond to her in that light. Given the brevity of her comments, I shall keep mine equally succinct, so that we can, hopefully, make some progress today. We seem to have been going at a relatively leisurely pace so far.

As the hon. Lady said, amendment 111 proposes that the Secretary of State's mandate to the NHS commissioning board should be subject to approval by Parliament. I welcome the opportunity to highlight once more how the Bill will strengthen accountability and parliamentary scrutiny. The mandate will set out what the Government expect from the board on behalf of the taxpayer. That will comprise progress against outcomes specified by my right hon. Friend the Secretary of State and objectives in relation to its core functions. For the first time, those objectives will be developed transparently through public consultation. The mandate may be changed only by agreement or in exceptional circumstances, and any changes must be notified and explained to Parliament.

For the first time, there will be transparency about what has been achieved. The board must not only publish its plan for how it intends to meet the requirements in the mandate, but report at the end of each year on how it has performed. Then the Department of Health must set out its own assessment of the board's performance and lay that before Parliament.

That represents an unprecedented step change in accountability to Parliament and to the public for how taxpayers' money is used by the NHS and what is delivered in return. In future, there will be far greater opportunities for parliamentary scrutiny, and I have no doubt that the Health Committee will want to consider whether it would like to have a role in scrutinising the mandate.

However, it is not necessary to take the extra step proposed by the amendment. Setting national priorities and outcome objectives is a core responsibility of the elected Government of the day. Parliament can and
should hold Ministers to account for how they do that, but that is not the same as requiring separate parliamentary approval for every decision.

Parliament will continue to have the opportunity to scrutinise ministerial decisions through questions and debates—and, for the first time, the Secretary of State will have to publish an annual report on the performance of the health service in England and lay it before Parliament. All the measures that I have set out enhance considerably not only the transparency of the process but the accountability to Parliament, for the reasons that I have given. For that reason, I trust that the shadow Minister will consider that she has fully probed the matter and will withdraw the amendment.

Emily Thornberry: I am grateful for the Minister's comments. I will withdraw the amendment, but I still want to say that the essential point is that the issue of health is of huge importance to all our constituents. Although some of us may have the honour of serving on the Health Committee, not all Members of Parliament can. The amendment would provide an opportunity for an annual debate in which all Members of Parliament could be involved in discussing the priorities of the national commissioning board. That is why we tabled the amendment. However, I hear what the Minister says and I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 112, in clause 19, page 16, line 23, after 'of', insert 'physical and mental'.

The purpose of the amendment is to require the board to have regard to the treatment and prevention of both physical and mental illness in carrying out its functions. This is another probing amendment, which we have been asked to put before the Committee because of concern among mental health organisations about the fact that health is mentioned in the clause only in respect of physical health, whereas it ought to refer to both physical and mental health.

The Government state on page 2 of their mental health strategy:

“We are clear that we expect parity of esteem between mental and physical health services.”

The amendment probes the role of the board in ensuring that services for people's mental health are given the same esteem as those for people's physical health. In other clauses of the Bill, the wording “physical and mental health” is used—for example, in proposed new section 3A(1)(a) of the National Health Service Act 2006, which is in clause 10. The amendment would simply ensure consistency throughout the Bill and reassure mental health organisations about the fact that health is mentioned in the clause only in respect of physical health, whereas it ought to refer to both physical and mental health.

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The Minister of State, Department of Health (Paul Burstow): I can quickly give the assurance that the hon. Lady and mental health charities seek in this regard. The amendment is not necessary because it is already provided for in section 275 of the National Health Service Act 2006, which defines “illness” as including “any disorder or disability of the mind”—that is from the Mental Health Act 1983—“and any injury or disability requiring medical or dental treatment or nursing”. The intention that we share, which is that there should be parity of esteem between physical and mental health—as the hon. Lady said, that is explicitly stated in the mental health strategy—is therefore fully reflected in existing legislation and has effect in the context of the legislation before the Committee today. I hope that, with that reassurance, the hon. Lady will feel able to withdraw the amendment.

Emily Thornberry: I am grateful for the Minister's comments; I am sure that they will give the mental health organisations some reassurance. However, I just raise again the point that I made about consistency. I understand what he says about section 275 of the 2006 Act. Presumably, that would apply also to proposed new section 3A(1)(a) in clause 10. The question is why that clause talks about mental and physical health, but other clauses talk only about physical health. I am sure that the civil servants have heard what I have said and perhaps the issue can be looked at again.

Paul Burstow: That point is helpful. We will certainly take a look at that. The intention of the strategy is clear and we want to ensure that the mental health charities and the hon. Lady are reassured that that intention is reflected in the existing legislation—and in this Bill, too.

Emily Thornberry: I thank the Minister. If only all our concerns could be allayed so easily. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 132, in clause 19, page 16, line 38, at end insert—

'(c) any reports or recommendations from local Healthwatch organisations, the Healthwatch England committee or local authorities (through overview and scrutiny committees or otherwise).'

The board has a duty to improve the quality of service. To do that, it has to have regard to the Secretary of State and NICE. We understand why that is and we understand that the board may well benefit from hearing from the Secretary of State and NICE when it comes to improving the quality of service. But why not also listen to the public and learn from them? If the coalition Government are to be consistent in what they say the Bill should be about—and they have often stated in florid language how important it is to listen to the public, increase democracy, shed light on the NHS and so on—then this is an opportunity for them to be so.

If the board listened to local healthwatch organisations and if something was happening on the ground that would affect a particular organisation—let us say a commissioning consortium was not fulfilling its role sufficiently well—the local healthwatch organisation could act as the regional alarm bell on that through HealthWatch England. The local authority might say the same thing.

Surely, in the furtherance of its role and its duty to improve services, the board should listen to local people before making a decision about what to do to improve the quality of service. It is a short point, but important nevertheless. This is not a probing amendment and I shall be interested to hear the Minister's comments.
Jeremy Lefroy (Stafford) (Con): I want to make a quick comment. The experience of Stafford and the Mid Staffordshire foundation trust shows that it is extremely important for the national commissioning board to take careful note of the comments of the LINks at the moment, the community health councils previously, HealthWatch in future, and lots of other local organisations.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): My hon. Friend makes a good point. Would he agree that the problem with the amendment is that it is far too prescriptive? It prescribes a limited number of organisations from which the board should seek representations, but a huge number of patient groups may operate in any one area. So, as with other amendments, this one is far too prescriptive. The general spirit of the Bill already encompasses the need to engage, and that is sufficient.

Jeremy Lefroy: I agree. There is a danger of being too prescriptive when there are many such organisations. Indeed, the national commissioning board should also pay heed to Members of Parliament should it write to them. I raised that point when I asked some of our witnesses whether they felt that representations from Members of Parliament were significant. They said that they were.

I agree that the national commissioning board must refer to representations made by a whole variety of bodies and individuals. To return to our experience in Stafford, one of the problems was that people from a wide range of bodies, individuals and organisations were not listened to, or had no real channel through which to communicate their concerns.

9.15 am

Paul Burstow: The amendment seeks to add a requirement for the NHS commissioning board to have regard to "reports or recommendations from local Healthwatch organisations, the Healthwatch England committee or local authorities" when discharging its duty to exercise its functions, with a view to securing continuous improvement in the quality of certain services. I agree with the hon. Member for Islington South and Finsbury about the important role that HealthWatch will play in the new NHS architecture, and about the importance of the NHS commissioning board having regard to the views of HealthWatch and local authorities. I do not believe, however, that the amendment is necessary to achieve that policy intention. I shall explain why by reference to each of the bodies mentioned in the amendment.

First, clause 166 will insert new section 45A into the Health and Social Care Act 2008, and it will provide for HealthWatch England to exercise the functions of providing information and advice to the NHS commissioning board about the views of people who use health and social care services, and of other members of the public, on both their needs and experiences of services. HealthWatch England will also provide the NHS commissioning board with information and advice on the standards of services and how they could be improved. I want to emphasise that that applies not only to local HealthWatch organisations, but to others as well.

Under new section 45A, the commissioning board will be required to respond in writing when HealthWatch England provides it with advice and information. Local healthwatch organisations will also have the function of producing reports and making recommendations to commissioners of services in relation to health and social care services and how they could or ought to be improved. As part of their role in addressing concerns about quality of care, local healthwatch organisations will also be able to enter and view the premises of health and social care service providers. That function will be carried forward from the local involvement networks, and a duty will be placed on providers to allow entry to their premises.

Local authorities will also continue to have powers, under the regulations in section 244 of the National Health Service Act 2006, to make reports and recommendations to NHS bodies, including the NHS commissioning board, on matters relating to the health service. The reports are not binding, but their subject has to respond to writing to the recommendations within 28 days when such a response is requested. We expect that to continue under the new system.

The NHS commissioning board will be required to be an active participant in the relevant activities of a local authority's health and well-being board. It will participate in the development of join strategic needs assessments and joint health and well-being strategies, and it will have to regard to both when undertaking its commissioning functions.

It is clear that there are already a range of different ways in which national HealthWatch, local healthwatch organisations and local authorities will be able to comment on the activities of the commissioning board and contribute to its work.

John Pugh (Southport) (LD): I seek clarity following the point made by the hon. Member for Stafford. There is an obligation to respond to the national HealthWatch, but suppose that, in future, a local healthwatch writes to the NHS commissioning board alerting it of something going wrong in the local health system. Is there an obligation under the legislation not for that to be received, but for it to be responded to by the board? In other words, could the board simply park the information? We all wish to avoid that.

Paul Burstow: Perhaps I can come back in a moment to my hon. Friend’s question and make sure that I give him a clear answer.

We have already discussed on a number of occasions the nature of the duty to seek to improve quality and how it will be pursued. Proposed new section 13D(4) makes specific reference to a document to be published by the Secretary of State, which we intend to refer to as the NHS outcomes framework, and to the NICE quality standards. The views of patients, carers and clinicians are an integral part of the way in which NICE develops its quality standards.

The NHS commissioning board will draw on those standards in setting the commissioning outcomes framework, against which the performance of consortia will be assessed, and in developing the commissioning guidelines to which the consortia must have regard when commissioning services. The commissioning board will have a specific duty to consult HealthWatch England on that guidance. That is the means by which the duty
to improve quality is given real effect and it is, therefore, the most effective point at which HealthWatch can contribute.

I hope that I have been able to demonstrate that consultation and engagement are hard-wired into the new system. As to my hon. Friend’s point about the relationship between the local healthwatch and the NHS commissioning board, the local healthwatch has a route through HealthWatch England, as I have just outlined, to raise concerns and to ensure that they are responded to.

John Pugh: On a point of detail, I may have misunderstood what the Minister said, and I apologise if I have got it wrong. I got the impression that there was an obligation to respond to HealthWatch when it raised general matters of service delivery, but if we had not had a specific episode, as in Staffordshire, and HealthWatch took it on itself to write to the NHS commissioning board because it thought it should alert everybody, could the board simply park that information, which would be regrettable, or would it be under an obligation to respond, which would be desirable?

Paul Burstow: I am grateful to my hon. Friend, who is seeking clarification. The local healthwatch will be able to scrutinise local services, and national HealthWatch will be able to present its views to the NHS commissioning board. There will be an obligation in that regard to respond to HealthWatch England on such matters.

Having listened to these exchanges and the points that I have set out, the hon. Lady will, I hope, feel reassured that there are significant and new ways in the new system to allow HealthWatch and local healthwatch bodies to influence the system and to have their views properly taken into account.

Emily Thornberry: I am grateful to the Minister, but I have to say that he has not allayed my fears. The hon. Member for Central Suffolk and North Ipswich says that there are many different patient groups and many ways in which patients can express themselves. The point of the legislation is that it is putting in place a structure that everyone will, I hope, understand.

If we want to engage the public, we have to keep pathways clear, and people have to understand where they fit into things. However, as the hon. Member for Southport highlighted again so well, there has been some confusion during our exchanges. We are sitting in the calm of Whitehall, going through the Bill line by line, and there is some confusion about exactly how the pieces of the jigsaw fit together.

What about a housewife in Ipswich who did not have a copy of the Bill to hand on her kitchen table? It might be easier if the legislation were a little clearer. If the public are supposed to be at the absolute forefront of the changes in the legislation, let us put them at the forefront.

Paul Burstow: Let me put the public at the forefront of the Committee for the hon. Lady. Just to make things absolutely clear. Through HealthWatch England, the local healthwatch can report to the board, which would then have to take any concerns into account and respond to them. A very clear chain is set out in the legislation: local healthwatch, national Healthwatch, the NHS commissioning board—it could not be clearer. That provides a clear route by which concerns can be dealt with through the structures in the Bill.

Emily Thornberry: Buried in the Bill, there is a clause—I apologise because I did not catch what number it was, and I should know—that sets out that HealthWatch England can have some influence on the board.

However, what is the point of proposed new section 13D(4)(a) and (b)? I am quite sure that there are other clauses—I would be able to find them if I was little faster on my feet—in which the Minister could find an obscure route whereby the board would have to pay attention to the Secretary of the State or NICE: I am sure that that is in the Bill. However, we should make it clear to one and all that responsibility for improving quality of service is placed on the board, but that it has to learn from these other important groups.

Paul Burstow: The first point to make is that currently, there is no national body dealing with patient representation and involvement. We are establishing one in the Bill. That is an advance that I hope we all see as beneficial to patients’ interests.

We think it necessary to establish a clear route in the Bill. I remind the hon. Lady that clause 166 will insert a new section 45A into the Health and Social Care Act 2008, enabling HealthWatch England to exercise the function of providing information and advice to the NHS commissioning board. That is a clear route, and I went on to describe it further. [Interruption.] Indeed, I have just been given a note to confirm that what I have told her is correct.

We have discussed on several occasions the role of the NHS constitution, to which the NHS commissioning board must have regard. The constitution makes it clear in its principles and in the code that the board must take such matters into account as well.

Emily Thornberry: There are times when the responsibility of Government Front Benchers in Committee proceedings is caricatured as being not to give an inch. This is an inch that seems self-evidently to be common sense. There are so many concerns about the Bill, but this seems to be one that makes perfect sense even according to the Minister’s own arguments. The amendment ought to be acceded to. I urge my hon. Friends—and, indeed, Government Members—to listen to the arguments that have been made.

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 13.

Division No. 19]

AYES

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

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

NOES

Birse, 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.
Emily Thornberry: I beg to move amendment 133, in clause 19, page 17, line 14, at end insert—

‘(e) promote the involvement of the public in decisions taken whether by the Board or Consortia about the health services that are to be commissioned for their areas.’

The Chair: With this it will be convenient to discuss the following: amendment 134, in clause 19, page 17, line 16, at end insert—

‘(b) in this section “Public” means people or groups of people who receive services or who may receive services provided as a result of the exercise of functions by the Board or consortia.’.

Amendment 135, in clause 19, page 17, line 21, at end insert ‘and from persons with professional expertise in patient and public involvement and review and scrutiny.’.

Amendment 168, in clause 19, page 18, line 15, at end insert—

13KA Duty to encourage public involvement

The Board must make arrangements to ensure proper public consultation over significant reconfigurations of services where the reconfiguration will affect more than one commissioning consortium.

Amendment 116, in clause 19, page 18, line 21, after second ‘are’, insert ‘continuously’.

Amendment 169, in clause 19, page 18, line 21, leave out from second ‘are’ to end of line 22 and insert ‘consulted’.

Amendment 117, in clause 19, page 18, line 33, at end insert—

‘(d) ensuring that reasonable adjustments are made so that the views of people with any impairments or disabilities can also be sought in relation to paragraphs (a) to (c).’.

Amendment 136, in clause 19, page 18, line 37, at end insert—

‘(5) The Board must have regard to the outcomes resulting from arrangements made under subsection (2) when exercising its functions.’.

Amendment 137, in clause 19, page 18, line 37, at end insert—

‘(5) Where a local authority is exercising its powers in respect of section 175 of this Act, whether through an overview and scrutiny committee or otherwise, the Board shall include in its arrangements under subsection (2) for the local authority, whether through an overview and scrutiny committee or otherwise, to be consulted in relation to matters in paragraphs 2(a) to (c).’.

Emily Thornberry: These are more amendments about democracy, public accountability and scrutiny. We know that the board will be powerful and led by a talented gentleman who has had a key role in the national health service for a long time. It will be able to control consortia by wielding NICE guidelines and make decisions about the commissioning of services. There is continuing debate about what that means and about designated services, non-designated services, A and E services in London and so on.

9.30 am

The board will be very powerful indeed and we need to ensure, in the light of what is coming out day after day about what the power of the board will be, that it can be held to account. There is, of course, increasing concern about whether designated services only will be referable to the Secretary of State through the overview and scrutiny committees, and whether that means, for example, that the A and E of my hospital, the Whittington hospital, could not be referred to the Secretary of State through overview and scrutiny because it will not be a designated service. We need to have at least a little more control over the board than the legislation currently allows. If we have to have a commissioning board of this nature then, frankly, it needs more democracy than is outlined in the legislation.

The hon. Member for Sutton and Cheam, the Minister, provided some of the rhetoric when he stated:

“the new NHS will be...different. We will pull back the curtains and shed light on all corners of the health service. Accountability will no longer only stretch upwards (rather obliquely) to Whitehall, but also outwards - clearly and tangibly - to communities.”

Well, good—I am so pleased. How will I, as a housewife in Holloway, have some effect on whether the A and E of the Whittington hospital is to be closed if it is not a designated service and I cannot even get my overview and scrutiny board to refer it to the Secretary of State? How can I ensure that those services are designated, so that I can save my A and E department? That is the question.

Although there is a duty for the board to promote public involvement, it does not stack up to much. Where will the public and patient voice be heard by the board? Each and every one of these amendments seeks to strengthen the accountability of the board. If the Minister does not agree with them, perhaps he could tell us where he thinks public involvement is and how the public can exercise some power over the national commissioning board. We cannot see that sufficiently strongly, and we do not think that it gets anywhere near the rhetoric.

Assurances have been given to many people that this legislation will give the public more power. Frankly, a close examination of the legislation shows that that simply is not right as far as we can see. If I am wrong, please tell us.

Mr Steve Brine (Winchester) (Con): I have not heard the word “housewife” for a while.

Mr Burns: She is a lawyer.

Mr Brine: Never will I argue. Amendment 133 states:

“promote the involvement of the public in decisions taken”.

However, proposed new subsection 13F(c) states:

“promote the involvement of patients and their carers in decisions about the provision of health services to them”.

The patients are the public and the public are the patients. Short of adding more words, I wonder what the hon. Lady is trying to achieve with the amendment. I am not being highly critical; I merely seek more information from her.

Emily Thornberry: I understand that. That is an important point, but it is not a debating point—it is different. As a patient, one has a certain perspective and as a carer, one has a certain perspective. That is very different, however, from the issue of someone who lives in a community and wants to ensure that they know that their local hospital is of a good standard and that their local services are generally of a good standard.
Such a person may not, actively or passively, be a patient at that time, but they will have a slightly different perspective. The difficulty is that by just listening to patients and their carers, which must be done, one loses out on some of the wisdom of the public generally. The reason for these amendments is to ensure that we hear from non-professionals in many different guises. That is important.

If we read amendments 133 and 134 together, they state that the board should pay attention to the public, and that “public’ means people or groups of people who receive services or who may receive services provided as a result of the exercise of functions by the Board or consortia.”

Proposed new subsection 13F(1) refers to the duties of the board to reduce inequalities and promote patient involvement. Patient involvement is obviously important, but a duty to involve patients is too narrow. Amendment 133 would bring in the public, and amendment 134 provides a definition. Does the Minister agree that the public need to be confident that the health service is meeting their needs in a more general way?

Jim Shannon (Strangford) (DUP): First, I would like to clarify the position. A lot of this is not relevant to Northern Ireland, but I shall make a point on an issue that people have brought to my attention. I declare an interest as a type 2 diabetic. Diabetes is a very important factor in my life, as it is in the lives of many others.

What will happen as a result of this NHS reform in England and Wales will ultimately make its way to Northern Ireland and will set the guidelines for what we do in the future; I suspect that that is how it will work. The hon. Member for Islington South and Finsbury has just commented on the duties to seek advice. Diabetes UK has asked me to underline that it would wish for there to be duties to involve rather than duties to seek advice. That relates to multidisciplinary professional applications—in other words, more involvement.

Will the Minister indicate whether he is prepared and willing to accept having involvement, rather than advice? That would strengthen the legislation and give those involved with Diabetes UK—I have used that organisation as an example—and many other sectors the opportunity to feel that the legislation has been strengthened and is better for them as a result of the wording and terminology. That is a big point, which I ask the Minister to respond to.

Emily Thornberry: Mr Hancock, may I make an application? I apologise, but this is the first time I have spoken from the Front Bench on a Bill Committee. I believe I should have gone through all the amendments that I wish to move, rather than sitting down and having a debate on one bit and moving on again.

The Chair: I will come back to you.

Nicky Morgan (Loughborough) (Con): It is a pleasure to follow the hon. Member for Strangford, who mentioned diabetes patients. A number of organisations have concerns about and an interest in the whole area of patient and public involvement. There was an interesting discussion about the difference between patients and the public. In amendment 134, the public are defined as “people who receive services or who may receive services.”

That encompasses patients and the public as one and the same. However, I entirely agree that it is important to discuss exactly what “involvement” means.

A key principle of the Bill is that “there should be no decision about me without me.” The Government are very much bearing that in mind. I agree with what the hon. Member for Islington South and Finsbury said about hearing from non-professionals. A lady who is tragically suffering from ovarian cancer gave evidence. I asked her specifically about whether she wanted to be involved in giving advice on her care after she had had her treatment. What she said was interesting—although, obviously, she was concentrating on her treatment and her recovery.

However, many other patients, particularly those suffering from long-term conditions, such as diabetes—where I am particularly interested in those suffering from mental health conditions—have an interest in the matter and often access services for a long time. They understand the services and want to be involved in commissioning decisions—perhaps at the commissioning board level but, more importantly, I suspect, at the commissioning consortia level.

I would be interested to hear from Ministers what “involvement” actually means. We use the word “involvement,” and some of the charities and those involved have spoken to Ministers and their officials about exactly what that means. Whether there will be guidance or best practice on involvement, it would be helpful for those charities to know what the situation is.

John Pugh: I shall make my point quickly, as it has been made in part already. The housewife from Holloway—the hon. Member for Islington South and Finsbury—and the Ministers all want to promote further public involvement. The question is whether the amendments technically do that. I sensed the dawning recognition on the part of the hon. Lady that her amendments were almost redundant.

Although patients are necessarily members of the public, the public invariably and occasionally will be patients at times. If we look at the definition in amendment 134 of “Public”—“people or groups of people who receive services or who may receive services”—that is, NHS services—we have a perfect definition of patients. Therefore, the two amendments are entirely encompassed in the existing drafting.

Jeremy Lefroy: I understand what the hon. Member for Islington South and Finsbury is saying, and I have been listening closely to my hon. Friends. Also, I am heartened by the words of the proposed chief executive of the NHS commissioning board, Sir David Nicholson. In a letter to consortia, he made it clear that one of the absolute priorities of the board is to champion a patient-centred approach to developing health services. That comes from the man who is set to lead the board, giving a clear indication of the direction of travel.

The Chair: Emily, I invite you to speak to the other amendments.

Emily Thornberry: I am sorry for the confusion; it is entirely my fault.
In glancing at the other amendments, I see that the one other question has been raised by other Members. I am interested in what the Minister will say. If the definition of “Public” which I put into amendment 134 is the same as the definition of “patient”, and if there is legislation to show that patients and public are the same, then the amendment is unnecessary and we will take the obvious course.

However, it is important to ensure that the definition of “patient” is not only those who are currently ill and receiving treatment, but also those within a certain area who might in future receive treatment. If we are all together on that, I do not need to press the point further, but I think it is important.

Mr Brine: I want to add a voice. I, too, will be looking to the Minister to confirm that and to reassure us. We live in a country with a national health service and, as far as I am concerned, every member of the public is a patient or potentially a patient. That is clear in the Bill, and I back my hon. Friends’ points.

Emily Thornberry: I move on to amendment 135, which is to clause 19, at line 21 of page 17, inserting at the end:

“and from persons with professional expertise in patient and public involvement and review and scrutiny.”

Proposed new section 13G relates to the requirement for the board to seek advice from “persons with professional expertise”. That is all well and good but, while it is right for the board to take advice on physical and mental health, if the Government are serious about public involvement, the board must take advice on how best to promote patient and public involvement.

We are all politicians and believe that we are good at engaging the public and involving them, but that is not something that necessarily comes easily to everyone. If people’s training and experience is entirely in commissioning and managing health care, they might not be terribly good at best practice for engaging the public. They should go to those who do know, engaging other professionals—if it is needed, they should always get advice.

Grahame M. Morris (Easington) (Lab): A number of Government Members pointed out the intent—from the chief executive, for example—to involve patients more directly in the running of the service. Intent is a wonderful thing, but are we not beholden to hold the Government to account for what are fundamental changes to how our health service is being run, as enshrined in the Bill?

Who is to say whether, in a year’s time, Sir David Nicholson—much though he is admired in all parts of the House—will still be in charge? Many similar issues are not specified in the Bill, although we have the opportunity to do so. Government Committee members are voting down all the Opposition amendments, even the sensible ones—although I would like to think they are all sensible—as a matter of course and not as a matter of principle. I appeal to them to give some thought to their tactics.
exchanges between me and the hon. Member for Leicester West on Tuesday, it would be quite clear that, in the spirit of the example that she gave, I spoke in illustrative terms to explain the difference between what might happen in an urban area and what might happen in a rural area. For the hon. Member for Islington South and Finsbury to present that as a fact and misrepresent the context and what I said, and for the shadow Secretary of State, the right hon. Member for Wentworth and Dearne (John Healey), to go running to the Evening Standard, is a little beneath them.

Emily Thornberry: I have every sympathy for the right hon. Gentleman. When speaking as a Minister, he has to weigh his words and be very careful. The fact is that although he may have made an attempt to row back—

Mr Burns: No.

Emily Thornberry: His words can quite reasonably be—

Mr Burns: No, they cannot.

Emily Thornberry: Will the right hon. Gentleman just let me speak? I know that passions are very much raised by this topic; it is of huge importance to us all. All this misunderstanding—if that is what it is—could be cleared up if, when trying to pass the legislation, the Government were to be a little clearer about how designated services would be appointed, and when.

We heard the evidence at the beginning of the Committee, and we are supposed to be scrutinising the legislation, but a key point will be, “Who will have a voice when services are reconfigured?” The designation of services is an absolutely central issue for many of us; we need to know about it, but we have yet to have a clear answer. If there is confusion, it is confusion of the Minister’s own making.

Mr Burns: There is no confusion at all. The hon. Lady was seeking to misrepresent what was said. I agree that we need to discuss those things, and if we made a little more progress we could get to the relevant clauses and do so in detail.

Emily Thornberry: Let us, therefore, agree to amendment 168, which would ensure proper public consultation on significant reconfigurations. I am sure that if the right hon. Gentleman is going to do the right thing in relation to designated services and the reconfiguration of hospital services, he will not be afraid to add that to the legislation.

Amendment 116 would ensure the continuous involvement of individuals to whom the services are being or may be provided.

Mr Burns: On a point of clarification, the hon. Lady is about to speak to amendment 116. Unless I misheard, she told you, Mr Hancock, before the sitting began, that she would not press that amendment. There should not be any confusion.

Emily Thornberry: I am sorry. I thought that I said—and my note in red says—amendment 169. I might have misread my own notes. It is amendment 169 that I do not wish to press, not amendment 116.

The Minister can relax, as amendment 116 is a probing one. There is a concern that there might be a hiatus in public involvement between the end of the local involvement networks and the introduction of HealthWatch England. Many people involved in LINks are concerned that there might be a period, between the phasing out of the one body and the phasing in of the other, when the public voice will not be heard. Given that that will be a time of great change, it might be particularly important to ensure that the public continue to be listened to. I would like to hear how the Minister plans to address that problem.

Amendment 117 is again about public involvement, and would ensure that when the public are involved and consulted, particular arrangements are made for people with impairments and disabilities. Older people, and people with learning disabilities, communication difficulties, visual impairments and hearing difficulties, are often heavier users of the NHS than others.

Although it is always important to ensure that everyone is involved, it is perhaps particularly important in relation to the national health service that particular arrangements are made for people with disabilities. Given the Equality Act 2010 stricture that there be no substantial discrimination in the public sector, it is vital that the NHS commissioning board, along with all other parts of the new NHS structure, is accessible to such people. I just want to hear what the Minister has to say about this largely probing amendment.

I turn to amendment 136. Consultation is not sufficient by itself. We do not simply consult, tick a box, say we have consulted and go away. The Government place great emphasis on outcomes and not processes. The same applies to democracy. We do not just listen to what people say; I hope we pay some attention to it. We show whether we have learned from it and whether we agree to it. We need to ensure that the board has regard to achieving something as a result of listening to people, and is not just going through the process. That is the purpose of the amendment.

I am not proud of the wording of amendment 137; I appreciate that it is clunky and not in the clear King’s English of which I approve so strongly. However, it is important. Essentially, it means that the local authority overview and scrutiny committees, or their alternatives, should be consulted by the board, along with individuals, when making commissioning arrangements and decisions. It would not just be individuals; it could be local authorities that, again, will hold a bank of wisdom and knowledge from which it is important for the board to learn.

I have gone through the issues as fast as I can, and I hope in sufficient detail. There are a number of amendments of varying importance. Depending on what the Minister says, I might seek the Chair’s indulgence to vote on one or two.

Dr Poulter: I was intrigued by the hon. Lady’s point that she did not want consultation to be a tick-box exercise. Far too much of what the previous Government did throughout medicine—consulting patients or telling professionals what to do—was reduced to a tick-box exercise. Consultation with patients was far too prescriptive; there was no genuine listening to patients. As the Minister, my hon. Friend the Member for Sutton and Cheam, remarked earlier, the fact is that this will be the first
piece of legislation that enshrines a proper consultation and listening to patients at its heart. The Opposition should give some credit to the Government for that.

The hon. Lady did not draw attention to page 18 of the Bill, where proposed new section 13L specifically addresses public involvement and consultation. That is at the very heart of the White Paper and what the Government are trying to do—to have a genuine partnership between patients and professionals, and with the commissioning process.

Emily Thornberry: May I, then, acknowledge that an attempt is being made to involve the public in the NHS? It is just not being done very well. I did pay attention to proposed new section 13L, as some of the amendments I have tabled refer to it.

10 am

Dr Poulter: I thank the hon. Lady for her comments, and I am pleased that she has acknowledged that there is an attempt, as she puts it, to engage the public. I would say there is much more than an attempt; at the very core of the legislation is the process of better listening to patients and their experience and involving patient groups, and taking that on board in the commissioning of services. That has to be a good thing, and lies at the heart of the legislation.

I wonder whether the hon. Lady will clarify a point in her concluding remarks. She is keen to talk about the need for greater consultation, and I have made the case that that is already in the legislation. In addition, genuine patient involvement is already emerging in many hospitals and GPs’ surgeries. Through the collision of patient and clinician involvement there is an open discussion about potential treatments, which is happening with the choose and book system. It is also enshrined in the very nature of the patient consultation, which is, quite rightly, beginning to change and take shape and allows patients to have much more involvement in decision making.

The hon. Lady was earlier at pains to say that the emphasis on patient choice is not necessarily a good thing. If she values the voice of patients, genuine consultation, and patient feedback, could she explain that inconsistency? She attacked patient choice, but she is now saying that it is important to involve patients. I do not follow her logic or her train of thought.

I shall now conclude my remarks, but we have to give the Government a lot of credit for pushing forward patient choice, which is strongly evidenced in this clause and throughout the Bill.

Nicky Morgan: I want briefly to address amendment 135 and proposed new section 13G. My hon. Friend has set out the reasons why the amendment is not required, to which I would add that it talks about “persons with professional expertise”. I take the point raised by the hon. Member for Islington South and Finsbury, which is that we all think we are good at involving people, even if there are probably more talented people out there. Proposed new sections 13F and 13G talk about patients being directly involved, which is what we want, rather than just people with professional expertise. The amendment seems to be a recipe for removing patients from the board’s activities by involving another set of professionals.

I have two points for the Minister to clarify. The first is about obtaining advice. It is one thing to obtain advice but another to listen to it. Although that is a matter for the board, could the Minister say whether it will involve listening to such advice?

Mr Burns: Yes, it does.

Nicky Morgan: I thank the Minister for that response. My second point is about professional expertise. Organisations such as Rethink have told me that they would like reassurance on whether such expertise would include the full range of health and social care professionals. They want to be able to get professional expertise from all such people. Such clarification would be welcome.

Jeremy Lefroy: I would like to address amendment 168 by raising an incident which happened in my area some years ago and highlights one of the problems with the current system. The building of a new-build hospital, the University hospital of North Staffordshire, involved the tremendous reconfiguration of removing some 250 to 300 acute beds. We were all very grateful for the welcome provision of a much-needed new hospital, but the finance was constrained by the amount available under the private finance initiative.

Finance was the fundamental driving factor, nothing else, because incorrect and out-of-date population figures were used in the proposal. The error meant that the region was given a first-rate hospital that under-provided acute beds for an ageing and growing population; some may disagree with that. That reduction in the provision of acute beds in the region’s health economy was tied up in the provision of a wonderful new facility, which shows that the consultation was inadequate.

I hope that there will be similar projects in future, although not under private finance arrangements—certainly not under the arrangements that were made in this particular case, and in many other cases across the country, which were too expensive. We must be careful, if we are to have such new provisions, that the public are not misled by wonderful new facilities that require major reconfigurations with serious long-term consequences. Such consequences might be felt for 100 years; the University hospital of North Staffordshire replaced a hospital that was built more than 100 years ago. I would like to bring that to the Minister’s attention.

In some ways, I have sympathy for the aims of amendment 168. I am not in sympathy with some of the other amendments in the group, but as far as I can see, the hon. Lady’s point is covered by proposed new section 13L on page 18. I would like the Minister’s reassurance that in the case of new builds or massive physical reconfigurations, there will be proper consultation, unlike what happened in north Staffordshire a few years ago.

Mr Burns: We have had a useful and interesting debate. A number of points have been raised from all sides of the Committee, and in due course I will deal with some of the specific questions. The Government’s commitment to public involvement in the design and delivery of the health service has already been discussed in previous debates. Rather than repeating what has already been said, I will address each amendment in turn so that we can make progress.
To my mind, amendment 133 is not necessary. There is no need for an additional duty on the board to promote involvement in commissioning decisions. As some of my hon. Friends have said, that is already in the Bill under proposed new section 13L. The new section will place a duty on the board to make arrangements to ensure that patients, and others who may need to access health services, are involved in the planning of commissioning decisions about those services, and in proposals for substantial changes to those services. The amendment is not necessary for consortia either, as they will be covered by the same duty of involvement in proposed new section 14P, which reflects section 242 of the 2006 Act. The board will hold them to account in fulfilling that duty.

The duty in 13F—the proposed new section to which the amendment pertains—is intended to cover something different, which is shared decision making and individual involvement in decisions about people’s personal health care. As I have said, we have discussed the importance of people being at the heart of decisions about the provision of health and care services. Throughout the Bill, we have made that clear by describing “people” as both patients and individuals who may use health and social care services. It is therefore not necessary to define “public” in the Bill, because everyone is a potential user of health and social care services. I therefore ask the hon. Lady to consider withdrawing amendment 134, and I hope that has allayed her concerns.

Emily Thornberry: It has.

Mr Burns: The effect of amendment 135 would be to single out particular types of experts from whom the board would be required to obtain advice in order for it to discharge its functions effectively. That would involve those with professional expertise in patient and public involvement, and review and scrutiny. Specifying the type of advice that the board should seek not only overrides its autonomy, but will invite perfectly valid criticisms that one group is being prioritised over another. Proposed new section 13G to the 2006 Act will require the board to make arrangements to ensure that it obtains appropriate advice from people with clinical professional expertise, in order to perform its functions effectively.

Mr Brine: Would that measure allow the board to involve organisations, such as the Neurological Alliance, that have come together to provide expert advice on services within their portfolios?

Mr Burns: Absolutely. I can reassure my hon. Friend on that point, and I hope that my hon. Friend the Member for Loughborough was reassured by the point that I made prior to the intervention. We have not sought to specify in the Bill exactly what professional advice the commissioning board should take because we believe that that is for the board to decide. We do not want to be either restrictive or prescriptive, and I hope the Committee shares that view.

We recognise the valuable role that scrutiny plays in providing transparency, accountability and local challenge. That is why we listened, and responded to the consultation responses by giving local authorities flexibility on how to discharge the scrutiny function, while retaining the separation between executive and scrutiny functions by preventing delegation to the health and well-being board. The proposal that the board should be under a duty to seek the advice of those with professional expertise in review and scrutiny would blur the lines between executive and scrutiny, and compromise the ability of oversight and scrutiny functions to be critical of the board in the future. I am therefore not persuaded by amendment 135.

To my mind, amendment 168 is unnecessary. It proposes a new duty, in a new section 13KA, to require the board to ensure that there is a proper consultation on any reconfiguration involving more than one consortium. As I have said, consortia will be under a legal obligation to make arrangements to involve members of the public on major changes to services resulting from their commissioning plans, and the board will hold them to account for that. We fully support the involvement of local people in shaping their local health and social care services. We know the importance of that and have already covered it by placing a duty on the commissioning board in the Bill.

The board will publish guidance to consortia on public involvement. Consortia will be able to request additional advice and assistance from the board on those matters, and could ask it to perform functions on their behalf. Consortia will also be required to consult local authorities on any substantial changes to designated services. The scrutiny powers in relation to the services will be held by each local authority. We intend to provide scope through regulations for them to exercise those jointly, if necessary, but that would be for their decision.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): I am grateful to the Minister for giving way. I just want to clarify the difference that the Minister sees between any reconfiguration and major reconfiguration. There is a swathe of difference there.

Mr Burns: The hon. Lady makes a valid point, but there will be the proper checks, balances and accountability that I have explained for both major and other types of reconfiguration, and I hope she will be reassured by looking at the provisions. When we reach clauses 69 and 73 we shall examine in far greater detail the area of designation and relevant consultation. I hope that that, too, will help to clear the air. There is also relevance to a point made by the hon. Member for Islington South and Finsbury: we shall have the opportunity to seek answers to some of the questions that she has raised from time to time when we deal in detail with that part of the Bill.

Amendment 116 would require the NHS commissioning board continuously to involve and consult the public on commissioning planning and major service development. Adding the word “continuously” is not necessary. The proposed new sections 13F and 13L of the 2006 Act set out clearly the requirements on the board to make arrangements to involve and consult patients and the public in planning of commissioning arrangements, development and consideration of proposals for significant service change, and significant decisions affecting the operation of commissioning arrangements.

Those three areas cover key stages of commissioning, which would be of interest to patients and the public. The duty to make the necessary arrangements applies whenever those stages take place. It is therefore wholly superfluous to add the word “continuously” when involvement and consultation are an ongoing process.
Emily Thornberry: I am listening carefully to the Minister and understand where he is going. I suspect that it is in a slightly different direction from the question that I asked, which I suspect is my fault. The question that the probing amendments are intended to address is what happens at the end of LINks and the beginning of healthwatch. Will there be a period when the public will not be sufficiently consulted? That is the reason for the word “continuously” and that is the question we want addressed.

Mr Burns: I appreciate that clarification. The answer to the hon. Lady’s question is no, there will not be a hiatus or a gap—it will flow from one to the other. I hope that reassures her.

Amendment 117 would require that the NHS commissioning board make “reasonable adjustments” to involve and consult people with disabilities and impairments. I understand the importance of the issue to all members of the Committee. The amendment is supported by Mencap and hon. Members will sympathise with its intention. However, applying “reasonable adjustments” might narrow the clause’s focus to a specific group—in this case, people with impairments and disabilities. Proposed new section 13F sets out requirements for the NHS commissioning board to reduce inequalities and promote patient involvement in decisions about the provision of health services, and to enable patients to exercise choices. In practice, that means that the commissioning board might issue guidance to commissioning consortia—following consultation with the relevant groups of patients and members of the public—on improving outcomes of care for specific groups of individuals in relation to, for example, access issues.

In addition, the board will be subject to the public sector inequality duty in the Equality Act 2010, which will require it, when exercising all its functions—including making arrangements for patient and public involvement—to have regard to the need to eliminate discrimination on the grounds of disability, and to advance equality of opportunity for that group. I hope that provides reassurance.

Amendment 136 would place a duty on the NHS commissioning board to consider outcomes of public involvement and consultations. The amendment is not necessary. Meaningful consultation is about involving the public and letting them know the results and action necessary. Meaningful consultation is about involving the commissioning board to consider outcomes of public reassurance.

Amendment 137 aims to ensure that the NHS commissioning board is covered by local government scrutiny functions. As I have said, the Government recognise the valuable role that scrutiny plays in providing transparency and accountability. Local authorities will have flexibility on how they discharge the scrutiny function, while retaining the separation between executive and scrutiny functions by preventing delegation to the health and well-being boards. I am happy to confirm that paragraphs (c), (d) and (f) of clause 175(2) will ensure that the current regulation-making powers on scrutiny cover relevant NHS bodies. Paragraph 129 to schedule 4 inserts a definition of “NHS body,” and it includes the NHS commissioning board. That therefore enables us to ensure that the commissioning board is covered by scrutiny powers in the future.

The detail of which providers are covered will be set out in regulations. The intention is to extend the regulations to cover all providers of NHS-funded services, significantly extending the scrutiny powers available to local authorities, so that scrutiny can follow the public. Taken together, the changes ensure that the regulation-making powers apply to the new architecture, covering GP consortia and the commissioning board, and significantly extend them so that scrutiny can cover all providers of NHS-funded services.

Alongside the extension of scrutiny, the flexibility provided to local authorities can help ensure that local people can shape scrutiny to meet their needs and accommodate structures. My hon. Friends will agree that form should follow function, not the other way around, and in giving local authorities this flexibility, we can ensure that is the case. I do not, therefore, think that the amendments would add value to the clauses, which already do such things. I would therefore urge my hon. Friends to reject the amendments if the hon. Lady decides to press them to a vote.

The Chair: Order. May I explain the situation with groups of amendments? The accepted practice is that Members vote on the lead amendment. The Chair has the discretion to allow votes on other amendments if that is the Committee’s wish, but I need prior notice of that if I am to consider whether it would enhance debate in the Committee or the progress of the Bill. If there is a move to have votes on other amendments in the group, notice should be given to the Chair so that a decision can be made fairly and the person who tabled them can understand why certain decisions have been made.

Emily Thornberry: I have listened carefully to the debate, and Members may not be surprised to hear that I will not press my amendments to a vote, with the exception of amendment 168, which deals with proper consultation over significant reconfigurations. If you will allow me, Mr Hancock, I will put that amendment to a vote. I understand that I did not give notice of that, and I will obviously leave it to your discretion to decide whether I am allowed to proceed. However, the issue is important. This large Bill, which is of such profound importance, is being pushed through its different stages very quickly, and different aspects of it come out as we go along, so we have to run very fast to keep up. The importance of democratic accountability in significant reconfigurations becomes increasingly important in the light of some of the things that we learn as the Committee
goes along, be that as a result of what the Minister says or evidence from elsewhere. It is a little like the dance of the seven veils.

While a decision is being made, may I engage in passing with the hon. Member for Central Suffolk and North Ipswich on patient choice? He asked how I could, on the one hand, make disparaging remarks about patient choice, but wanted, on the other hand, patients to be involved. To be fair, I said that, for many of us, it would be ideal if we could sit down with our GP, get proper advice and information and make decisions about our health care. My difficulty is that not everyone is in that situation; people may be too ill, they may have a mental condition, they may have complex needs or they may not have English as a first language. When it comes to equality of access, we have to be mindful of such things.

If the hon. Gentleman believes that patient choice or patient involvement simply mean sitting down with a GP and making a decision about care and that that is sufficient, I would respectfully say that he has been misled. To draw an analogy, McDonald's is not a democracy just because people can chose which burger they want; there is much more to patient involvement than simply shopping for the right treatment. We need the patient voice to be heard, not only at a time of crisis, when people need to speak to their doctors, but more generally. Just so that we understand each other, let me say that I am not against patient involvement or patient choice, but things are a little more complex than they might seem from the way in which they have perhaps been caricatured. [Interruption.]

The Chair: Order. For the record, it might be helpful if the Minister clarified the position from a standing position, rather than a sedentary one.

Emily Thornberry: In fact, I was referring not to the Minister, but the hon. Member for Central Suffolk and North Ipswich. I thought it was only right to respond to him, given that he had asked me a question.

The Chair: I have decided that we will have a vote on amendment 168, but it will be taken at the appropriate time on the agenda, which may be sometime this afternoon, after amendment 165 is disposed of. We cannot vote on amendments before we have dealt with earlier amendments.

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

Amendment, by leave, withdrawn.

10.25 am

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

Adjourned till this day at One o'clock.