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GENERAL COMMITTEES

Public Bill Committee

HEALTH AND SOCIAL CARE BILL

Twelfth Sitting

Thursday 3 March 2011

(Afternoon)

CONTENTS

CLAUSE 19, as amended, agreed to.

CLAUSES 20 and 21 agreed to.

SCHEDULE 2 under consideration when the Committee adjourned till
Tuesday 8 March at half-past Ten o'clock.

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The Committee consisted of the following Members:

Chairs: MR JIM HOOD, † MR MIKE HANCOCK

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

Public Bill Committee

Thursday 3 March 2011

(Afternoon)

[MR MIKE HANCOCK *in the Chair*]

Health and Social Care Bill

Clause 19

THE NHS COMMISSIONING BOARD: FURTHER
PROVISION

1 pm

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 113, in clause 19, page 17, line 21, at end insert—

‘(2) In discharging its duty under subsection (1), the board must make arrangements with a view to securing that it obtains advice from—

- (a) persons with professional expertise in the commissioning of cancer services, and
- (b) persons with professional expertise in the clinical delivery of cancer services.’

The Chair: With this it will be convenient to discuss the following: amendment 114, in clause 19, page 17, line 21, at end insert

‘including audiology and hearing loss services’.

Amendment 115, in clause 19, page 17, line 27, at end insert

‘insofar as making such payments does not to any significant extent interfere with the performance by the Board of its functions.’

Emily Thornberry: The origin of amendment 113 is similar to that of the amendments on public health that we discussed earlier. Cancer Research UK has suggested the amendment, as it is very concerned about some of the changes and would like reassurance that the support of cancer experts will be sought by commissioners through the transition to new commissioning arrangements and beyond. To commission effectively, commissioners require information about appropriate levels at which to commission certain services, what an excellent service looks like and the current quality of different services.

Amendment 114 is designed to ensure that the NHS commissioning board has a duty to obtain expert guidance on all conditions, including hearing loss—guidance that can be passed on to local commissioning consortia. This is a probing amendment, suggested by the Royal National Institute for Deaf People. It is designed to elicit clarification of how expertise from the commissioning of services for all conditions, including hearing loss, will be retained under the proposed new system. Under the proposals in the Bill, audiology and hearing loss services will be commissioned locally by GP consortia. The RNID is concerned that GPs have low awareness of the needs of people who are deaf or hard of hearing.

I have spoken to people who have deaf children. The Labour Government introduced a system whereby the hearing of newborn babies would be tested. Although there is now an obligation for newborn babies to be

tested, the concern is that if someone finds themselves with a baby who is deaf, they must have help straight away, because children need to learn to speak before they speak. The concern is that if they are not given proper hearing aids and proper support, they lose to a much greater extent than is necessary their ability to speak. GPs struggle at the moment, and the concern is that with the changes that situation will get worse. I raise that as a specific issue that has been raised with me. I have friends with a severely deaf child. Thankfully, they found out that the child was deaf at an early stage and the child can now talk, but many children who are not caught at an early stage simply do not end up talking.

Recent research shows that GPs fail to refer up to 45% of people reporting hearing loss for any intervention, such as referral for a hearing test or a hearing aid, so will the Minister clarify what form the duty to obtain advice will take? Can he also confirm that the board will take advice on all conditions, including hearing loss, and that that will be passed on to all commissioning consortia?

I come now to amendment 115. We are in straitened times in which rather than increasing the budget for the NHS, the Government are breaking their promise to protect it. In these circumstances, we need a balance in incentivising innovation and commissioning vital services, so will the Minister tell us more about the level of payments and the number, and what he has in mind, particularly given our straitened economic circumstances and the £20 billion efficiency savings that need to be met?

The Minister of State, Department of Health (Mr Simon Burns): The effect of amendments 113 and 114 would be to single out particular types of experts from whom the board would be required to obtain advice so that it could discharge its functions effectively. Proposed new section 13G inserted into the National Health Service Act 2006 under clause 19 would require the board to make arrangements with a view to ensuring that it obtains appropriate advice from people with clinical professional expertise to enable it to perform its functions effectively. 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 and we have trust in the decisions it will come to, just as we trust Sir David Nicholson to make the right decisions of that nature. Specifying the type of advice that the board would seek not only overrides its economy, but would invite perfectly valid criticisms that one group is being prioritised over another.

Turning to amendment 115, proposed new section 13H places a duty on the NHS commissioning board to promote innovation when exercising its functions, including innovation in the commissioning of services, as well as in the provision of health services. That duty, similar to the duty that applies to the Secretary of State under the Health Act 2009, will support the commissioning board in discharging its duty to exercise its functions with a view to securing continuous improvements in the quality of services provided under proposed new section 13D to the National Health Service Act 2006, inserted under clause 19.

Proposed new section 13H also enables the commissioning board to make payments as prizes to promote innovation in the provision of health services.

The amendment was tabled because members of the Committee considered that the board might use funds for awards for innovation that could be used more effectively by the board, for example, to commission front-line services. Let me provide assurance: first, the provisions for promoting innovation are intended to support the delivery of quality and productivity improvements across the NHS in order to help transform health care for patients and the public. In other words, should the board choose to use the power—it is a power rather than a duty—it might do so as one way of promoting innovation in the provision of health services.

Innovation prizes are currently awarded only if there is clear evidence that value has already—or will be—delivered, whether financial or health gain, and that the innovation is replicable and cost-effective. Prizes help foster an enterprise and innovation culture in the NHS. The Secretary of State already has power to award prizes and the proposed new section 13H simply gives the commissioning board the same power. I believe that, for those reasons, the amendment would serve no purpose.

For example, if the board chooses to make payments to encourage investment in a particular service, far from being a distraction for the board in performing its other functions, the measure would support its doing so. I therefore urge the hon. Lady to withdraw her amendment and, if she is resistant to my recommendation, I will ask my hon. Friends to join me in voting against it.

Emily Thornberry: I am disappointed in the right hon. Gentleman's response to amendments 113 and 114. Two particular groups have worries and have asked that the amendments be tabled to seek assurance from the Minister that those conditions will be treated seriously and that there will be appropriate support.

Mr Burns: I am sorry that the hon. Lady is disappointed, although that is her right. However, I assure her that all conditions, including those ones, will always be taken seriously.

Emily Thornberry: If that is the only scrap we are to get, then that is the scrap we will get, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 172, in clause 19, page 17, line 39, at end insert—

‘13IA Duty in respect of regional strategic planning

The Board must, in the exercise of its functions and in partnership with commissioning consortia and Health and Wellbeing Boards, take responsibility for regional strategic planning of the provision of health services for the purposes of the NHS and take action to implement those plans, with particular regard to—

- (a) the current health needs of regional populations;
- (b) the future health needs of regional populations;
- (c) the regional configuration of major health services for the purposes of the NHS;
- (d) investment in capital infrastructure for the purposes of the NHS;
- (e) the development of integrated pathways of care for individual conditions;
- (f) the development of clinical networks.’

The Chair: With this it will be convenient to discuss amendment 173, in clause 19, page 19, line 35, at end insert—

‘(2A) The business plan must include details of regional plans as to how the objectives will be achieved, including through collaboration with and between commissioning consortia for those population groups.’

Emily Thornberry: I shall be brief, because the Committee has heard in earlier sittings many of the arguments on the importance of regional strategic planning. I do not intend to repeat them. However, as I said before lunch, the issues raised by the Bill are constantly evolving and we are hearing them more and more.

I do not know whether the Committee members have had an opportunity to read, for example, the press release from the King's Fund, which was embargoed until midnight last night. It stated:

“Market forces alone will not deliver essential changes to hospital services.”

I want to read out a particular highlight because, as I said, things are moving so fast that we all need to keep up. As things change, we need to keep reconsidering the risks attendant on the Bill.

“The report highlights the need for strong, strategic commissioning to reconfigure some services such as cancer, cardiac and stroke care across large geographical areas. It argues that this will not be delivered by the government's health reforms, which will abolish the strategic health authorities currently responsible for leading this work and leave GP consortia to fill the gap, a task they are unlikely to be able to fulfil.”

The King's Fund is not no one. It knows what it is talking about. It warns the Committee and the Government that, if regional strategic health authorities are abolished and not replaced with anything from the national commissioning board, health will suffer. That is important, and I urge Government to consider it. They should look at it again.

We heard from Sir David Nicholson, who was careful in what he did not say—in so far as one could understand his evidence at all. I agree with the comments of my right hon. Friend the Member for Rother Valley about that evidence. With respect, Sir David was obscure and oblique, to say the least, on whether the national commissioning body would have some form of regional bodies—but common sense surely dictates that they must have regional bodies, otherwise health will suffer. The amendment attempts to deal with that problem, which will continue to haunt the Government.

John Pugh (Southport) (LD): The amendments go to a central and crucial issue of the legislation. I am not sure that they are the solution to the difficulty foreseen, but they are certainly a basis for us to air and debate what appears to be a central problem with the legislation. No one in this room would not want to see a regionally integrated pattern of care for many ailments in an area. In fact, probably hardly an area in the country does not have a pattern of care or such an integrated pathway.

In my own area, people who suffer with a renal problem certainly have to go outside, to use facilities that are part and parcel of the general Merseyside NHS. For cancer services, people go from the northern side of Merseyside to the Wirral, to get service at Clatterbridge, which is part of the cancer system of care. Equally, paediatric services in my own constituency are skeletal and we, to a large extent, depend on nearby Alder Hey being part of an integrated pattern of care.

[John Pugh]

The normal way of delivering the integrated pattern of care in the past was through regional commissioning groups which are, ultimately, the creatures of strategic health authorities. That is how they happened, in a top-down, planned way. Everyone accepts that the result, a sensible clinical network for a range of complaints and issues, is not only a highly desirable outcome but a crucial one. That was always going to be made more difficult by introducing elements of competition into the NHS. The previous Government were guilty of doing that. I remember asking in many debates how to square the circle of the drive to get competition, which most people seem to want to improve efficiency, and the drive for collaboration, which we also want, as that leads to efficiency as well—we can get resource efficiency if people collaborate better and do not try to reinvent the wheel in all corners of the NHS.

1.15 pm

As a result, there is schizophrenia at the heart of the modern NHS, which is replicated in the Bill in the role of Monitor. How do we address that? I think the Government recognise that it has to be addressed one way or another. They would fudge it by saying, “There is a place for competition and a place for collaboration, and we have to get the balance right.” Normally, the balance is got right by a managerial solution that is based in a strategic health authority. The Government are offering another way of trying to get that balance right by putting certain levers in the system, which is largely made up of independent pieces, to ensure collaboration. For example, commissioning boards will be encouraged to think collaboratively and marked on how far they collaborate. It will be helped by the fact that clinical networks that are planning from the top will appear from below; they will grow like some kind of neural pathway. That is an untried solution in parts. It is an interesting idea—and I do not know whether it will work—but if it does not work, we will be in trouble.

At any rate, we need to have, if not something like a regional health authority, some kind of backstop that surveys the region and ensures that all the clinical networks are in place and that they all work. Therefore, I think there is merit in considering the issues raised by the amendment, even if the amendment itself has certain flaws. The Government seem to be introducing an accomplishment that is harder to deliver than having someone watching over the shop, as they do now, and ensuring that all the bits fit together.

Mr Steve Brine (Winchester) (Con): In our first evidence session on Tuesday 8 February—a long time ago now, it may seem—I asked Sir David Nicholson about the regional structure. He said:

“You highlight the dilemma. On one hand, you have a national body, but on the other hand, it will be commissioning very local services, so you will need more people working for the board operating on a more local level.”—[*Official Report, Health and Social Care Public Bill Committee*, 8 February 2011; c. 10, Q19.]

John Pugh: Therefore, what we have in a sense—it looks slightly embarrassing—is a re-creation of regional health authorities, except that they are to be called sub-branches of the national commissioning body. Whether

there will be a committee, or whether the sub-branches will be posted out in the north, west or east and be called strategic health authorities, I do not know. Those of us who are on the health scene know that people in the SHA are in and out of Richmond house all the time. It makes little difference what we call the bodies; what is important is that the role is fulfilled. Whether it is fulfilled by a national commissioning body with regional committees or sub-branches or by a SHA would make little difference. I suspect—this is almost a joke in the health field at the moment—that we will have to create regional committees. We may end up creating a different number of regional committees to avoid the embarrassment of saying, “We have recreated SHAs”, but one way or another, we will not get rid of that crucial role. The amendment draws attention to the need for that role to be filled. I do not know whether it is a right amendment, and I shall not vote for it, but none the less, it is a serious issue that we need to debate properly in Committee and probably on Report.

Owen Smith (Pontypridd) (Lab): As the hon. Member for Southport said, the two amendments refer to a critical part of the Bill, and indicate a critical absence in the Bill of provisions that address strategic planning. The hon. Member for Winchester said a moment ago that Sir David Nicholson attempted to wade into that issue in his evidence, referring to the need for some regional tier. I think that we all recognise the need for that, but the fact that Sir David brought it up, bluntly, in such a haphazard fashion, and conceded that he had not done the work that was needed. That and the fact that nothing in the Bill stipulates how it will be arrived at, save that the NHS commissioning board will have the capacity to appoint committees and sub-committees, prompts the simple question of how that will be done.

At what level will the regional tier be instituted, and how many people are going to be employed by the NHS commissioning board at a regional level? In which regions will there be tiers, what boundaries will be observed and on what precise criteria will they be based? The list of questions is endless. It seems to us on the Labour Benches that those questions are crucial and have clearly not been addressed.

Jeremy Lefroy (Stafford) (Con): Does the hon. Gentleman agree that it is a welcome innovation that, as far as I understand from a letter from Sir David Nicholson, the NHS commissioning board will be based in Leeds and not in London, which is an indication that the Department of Health and all its functions will be far less London-centric than they have been in the past?

Owen Smith: I do welcome that, although large chunks of the Department of Health are already based in Leeds. That reveals a transfer of staff from the Department of Health to the new quango, which is not necessarily positive, because it is another example of direct control over the NHS being removed from the Secretary of State and of more of the actors and expertise in the NHS being put into the hands of that quango.

The fact that the board will be in Leeds is, however, good. More Government jobs should go to the regions—I would say that more should go to Wales, in particular. I

am not sure that Leeds is—[*Interruption.*] That is not what I was saying. I said “Government jobs,” which are not necessarily health jobs.

The confusion over regional tiers should be addressed in the Bill, and another area of confusion that the Minister might clarify today relates to designated services, because those two matters are linked. If we have no regional planning levels, and we have wide variations in the size of GP consortia and therefore in their ability to plan strategically at a regional level, the role of Monitor in designating services to protect things of strategic regional importance becomes critical.

That takes us to the Minister’s comments on Tuesday about the designation of accident and emergency services in London. This morning, he attempted to suggest that he had not said what I think we all believed he had. Looking at the record, I see that my hon. Friend the Member for Leicester West asked:

“Let us take A and E services in London. There are a lot of them—more than one. Does that mean that they will not be designated?”

The Minister responded:

“As to A and E, I suspect the answer is that no, in London—or, probably, in most parts of London—it will not be a designated service for the very reason that the hon. Member for Leicester West gave, which is that there is a significant number of A and E services in London. There would not be a need to designate them, whereas if one were talking, for example, about a predominantly rural area such as Cornwall, off the top of my head, A and E services would be designated, to ensure that there would be provision of that service for the people of that rural area.”—[*Official Report, Health and Social Care Public Bill Committee, 1 March 2011; c. 348-349.*]

Mr Burns: Will the hon. Gentleman give way?

Owen Smith: I will in a moment. I do not think that that was a “for example”; it was a lengthy disquisition on the fact that the Minister suspects that, in his opinion, those A and E services will not be designated. Will he clear up the example of Chase Farm—will it be a designated A and E service, or will it close?

The Chair: Order. I do not think that that is pertinent to the amendment. If the hon. Gentleman wants an answer about a particular hospital, I do not believe that his question is pertinent. We need to be clear about what we are debating.

Mr Burns: Mr Hancock, I shall certainly not discuss Chase Farm, because you are absolutely correct that that does not come within the amendment, but I hope that you will allow me to read the rest of the quotation, because what the hon. Gentleman quoted distorts the whole context of what I said by omitting the following sentence.

The Chair: To be fair, Mr Burns, those are issues for debate and members of the Committee can interpret what has been said. All hon. Members have the ability to read what was said and those who were here understand what was said. If hon. Members cannot understand that, that is their problem. I do not think it is for you to rehearse again the reasons why you said what you said.

What is written—I have read it very carefully—stands. I fully understand it and I would hope that other hon. Members would as well.

Owen Smith: Thank you, Mr Hancock. I absolutely understand it. I quoted from it at length so that I would not run the risk of distorting it. It is very clear, on the record, and hon. Members and the public can make their views known. With respect, I feel that Chase Farm is an example of one of the designated services, which is why I brought it up, and I am disappointed to hear that the Minister cannot confirm that it is going to stay open.

Nick de Bois (Enfield North) (Con) *rose*—

The Chair: Order. I have already made a decision that that is not pertinent to the debate. Hon. Members can raise questions about individual hospitals, which are not mentioned in the Bill, in other places. I do not want a discussion on the future of a hospital. It is unfair to the hospital concerned and does no credit to the Committee.

Mr Burns: On a point of order, Mr Hancock. I totally agree with what you have just said. But do you share my concern about what the hon. Member for Pontypridd has just done? He has attributed to me something that I have never said, and it is unfair to use a cheap procedure to get something that is simply not true on the record.

The Chair: To be fair to you, Mr Burns, you will have a chance to comment in a minute. I will ask you to clarify exactly what you meant, because I think it is unfair to the people who work in that hospital and the community around it to have speculation at this stage in the Bill. I am sure every member of the Committee could raise equally speculative questions about hospitals in their areas, and I do not think that that would do justice to those circumstances or to the work of the Committee.

Nick de Bois: On a point of order, Mr Hancock. As the hospital is in my constituency, may I say that however the passions may be aroused, it does not serve my hospital well to have it discussed in such terms in this context, given the immediate situation facing us? While I can understand that it may come up as an example of reconfiguration later, it is wholly inappropriate to raise it out of context.

The Chair: Can we put the issue aside now? What has been said has been said. Let us move on and try to avoid speculation on individual hospitals—[*Interruption.*] Mr Barron is laughing. It does not help our debates, Mr Barron, and I am sure you would be the first to agree if you were still Chair of a House Committee. You would not stand for such speculation, and nor will I.

Owen Smith: In conclusion, the amendment is excellent. Regional planning is a crucial gap in the Bill and I urge all members of the Committee to support it.

Mr Burns: Mr Hancock, I will take you up on your advice to clarify one or two points before I get on to the individual amendments. If we are to have an intelligent debate on the Bill—as we have, by and large, for the vast majority of the time—it is unfair and rather reprehensible

[Mr Simon Burns]

if hon. Members start attributing views to Ministers or other hon. Members that are completely foreign to the truth. What I said on the question of Chase Farm, which is all I would say, is that it would be totally inappropriate for me as a Minister to discuss Chase Farm at the moment in this forum, and I would not go down that route. That is what I said. To be accused by the hon. Member for Pontypridd is very unfair.

1.30 pm

To go back very briefly to last Tuesday, it may be terribly clever to misrepresent a Committee member's speech to a journalist, but one has to be accurate. The hon. Gentleman did not read what I said next. On the question of urban versus rural areas, I used the example of the hon. Member for Leicester West—London A and E—and the rural area of Cornwall, which I chose. I said:

“The hon. Lady is being a little unfair. I gave that as an example because she gave it as an example. I was extremely careful to say that I would not say what services were or were not going to be designated. To be helpful to her—although I will be more cautious in future—I was giving an illustration between a very built-up, urban area and a rural area simply to get across the general point of how we anticipate designated services would work.”—[*Official Report, Health and Social Care Public Bill Committee*, 1 March 2011; c. 349.]

Because the hon. Lady did not quite get that at the time, she kindly allowed me to intervene twice to reiterate and reinforce the point. If hon. Members try to cause trouble for others on this Committee, they should do so in the context of the discussion and of precisely what was said.

Owen Smith: Will the Minister give way?

Mr Burns: No, I will not, because there is nothing more to say. The context of my comment was clear—it was an illustration, not a policy announcement.

The amendments are tabled in the belief that there is a question about how well consortia will be able to work collaboratively to develop joint strategies and manage changes to services that cross organisational boundaries. That belief has been clear from the other amendments that have been tabled on this topic.

Opposition Members refuse to accept, however, that consortia and local authorities can co-operate effectively on such matters. The amendments represent the Opposition's solution, which appears to be a return to the strategic health authority model and command and control.

Grahame M. Morris (Easington) (Lab): Will the right hon. Gentleman give way?

Mr Burns: Not yet; I shall make a little progress. The reforms in the Bill are intended to put patients and clinicians in the driving seat. They will enable patients to exercise genuine choice on the basis of information that is of real use to them, and to take decisions about their care in partnership with those clinicians whom they trust most to help guide them through the system. Investment will follow the patient, which will drive innovation and reward those providers who respond to patients' needs and demonstrate that they deliver the best outcomes.

The amendments would take that power out of the hands of patients and general practitioners and place it with the NHS commissioning board. They propose that the board should have responsibility for regional planning and development, and should take action to implement such plans.

Of course, the commissioning board should be involved in developing those proposals. I have said that they will be required to participate in the preparation of the local joint health and well-being strategies and joint strategic needs assessments. Those will also be essential in informing and guiding the commissioning board's own approach to commissioning primary care and other services that it might commission. Under new section 14X of the 2006 Act, inserted by clause 22, the commissioning board may

“provide assistance or support to a commissioning consortium” on such terms as may be agreed to support it in fulfilling its functions. The commissioning board will even be able to carry out functions on behalf of a single consortium under new section 14W, or on behalf of a group of consortia, at their request, which might be for support with consultation and planning on large-scale changes.

I agree that it is vital that patients continue to experience integrated pathways of care, and the reforms will create greater scope for developing such pathways. The commissioning board has a crucial role to play through the quality standards that it will commission from the National Institute for Health and Clinical Excellence, which will inform the commissioning guidance that the board will provide for consortia, and through developing tariffs that can be structured to encourage integration where necessary.

The White Paper was clear that the board will provide support in hosting the commissioning networks that are so vital in supporting and delivering service integration. Overall, the role of the commissioning board should be to provide support and assistance to consortia to enable them to do their job to the best of their ability.

However, I am afraid that the amendments would create conflict between the board and the bodies that we are making responsible for leading on the decisions locally. What happens if the board disagrees with the direction of travel that the health and well-being board agrees or about the areas in which consortia want to direct investment? There is a great risk that the result would be to continue with outdated service models that are not responsive to the views of clinicians or the needs of patients.

The hon. Member for Southport said that we needed a backstop to ensure that clinical networks were happening. I share his view on the importance of clinical networks; the question is about the mechanism that we use to achieve them. We cannot agree that the only way is through a regional tier. The Bill will greatly increase clinical involvement in the running of the NHS, and I hope that the hon. Gentleman will agree with that. It will be up to the commissioning board, during its shadow existence, to determine exactly what type of local presence it will have. That must not be predetermined.

The abolition of primary care trusts creates an opportunity to find the best solution for different services. That is something that the shadow board will be examining, with primary care clusters, in the coming year, so that they can develop a relevant, locally based system that meets the needs of the whole country.

John Pugh: The Minister has not said yet, although I suspect that it is implied in what he says, that there will be joint health needs assessments of a regional kind as well as of a local kind. May I give him a particular example? I happen to have in my constituency a fine renal facility, which is there because a need has been identified in the region. Why is it in my constituency rather than in another one? Because mine has a high number of elderly people with renal problems.

I can see the same situation replicating itself in years to come and the suggestion being made that a considerable amount of resource be invested in my constituency in a renal facility, but other individual commissioning bodies preferring to have the facility elsewhere and there being no agreement about what will happen. As a result, the regional configuration of the services will not end up looking ideal at all. If the Minister could convince me that that will not happen without someone looking at the whole situation from the top and taking a regional view, I would be more comfortable, but so far he has not done so.

Mr Burns: I will certainly try to reassure the hon. Gentleman. First, I should say that I am going to divorce my answer from having anything to do with the positioning of the renal unit in his constituency, so that we do not get into the position in which I found myself, through no fault of my own, last Tuesday. I particularly ask the hon. Member for Pontypridd and the right hon. Member for Wentworth and Dearne (John Healey) to note that before they start to misinterpret what I am about to say.

Obviously, one cannot predict what will happen in future, but the issue will be determined by the needs of patients, locally and regionally. Decisions will then be taken that will establish the most relevant place and the number of units that are needed to meet the demand of patients in the part of the country under discussion, as well as in other parts of the country. Therefore, in one way, I cannot give the hon. Member for Southport a definitive answer as to what will happen, because at this stage in the process there are too many unknown quantities and unknown—

Emily Thornberry: Unknowns.

Mr Burns: Yes, unknown unknowns. I am grateful to the hon. Lady—if only I were a lawyer. There are too many unknowns. I hope that the hon. Gentleman will accept that, because it is crucial that local demand and local needs should be the driving force in ensuring that units of any type are configured and placed where they are most relevant.

John Pugh: The Minister used the words “command and control”. The strategic health authority in my area did not give me a renal unit because of command and control, but for precisely the reason that he has just marked out. It did an assessment of local needs and where the local needs were, and they were predominantly in constituencies with elderly populations as opposed to more mixed populations. I am not disputing that that is what will happen in future, but my argument is about the most successful mechanism for achieving that end, given that the case of a strategic health authority distancing

itself from a whole lot of local interest and looking across the piste to see what was clinically desirable and where the need was seemed to have worked, as a model, quite well.

Mr Burns: I am grateful for that further information from the hon. Gentleman. I shall repeat my proviso: I do not want to get into a discussion about his own unit because that would cause me too many problems. I also do not know enough facts about the determining influences, apart from a need for a unit, that meant that it ended up in his constituency.

My original point was that local demand and needs should be the driving force behind the most appropriate place to put a unit or a facility to meet the needs of patients.

Grahame M. Morris: I am following on from the points made by the hon. Members for Southport and for Winchester who asked some incisive and thoughtful questions of the chief executive of the health service. The provision is the emperor’s new clothes clause in that everyone with a bit of an informed opinion accepts that we need a regional dimension to the decision-making processes. Whether or not the Minister is willing to concede that, will he rule out the prospect of ever developing it in future? Many issues, apart from the essential integrated clinical networks, have been mentioned. For example, cancer care networks are absolutely critical to delivering the improvements that we want to see.

The Chair: This is getting close to a speech, Mr Morris.

Grahame M. Morris: It is essential that we do not just throw the baby out with the bath water.

Mr Burns: The hon. Gentleman said that all informed opinion suggests that there should be regional networks, whether SHAs, regional boards or whatever. I am slightly hurt because I also consider myself informed. I certainly think that my hon. Friends here are, and we do not share his view. If the amendment were to be put to a vote, I urge my hon. Friends to join me in rejecting it.

Mr Kevin Barron (Rother Valley) (Lab): Let me try this again in a different way. Cancer survival rates have been improving in this country for a considerable time. We debate European comparisons, but one of the reasons why they have improved is that, under the cancer plan, hospitals started to be identified that would be better at cancer surgery, because the success rates differed from hospital to hospital. As a consequence, survival rates are better than they were a decade ago. My question to the Minister is whether anything in the Bill is likely to stop that happening and turn the clock back or stop it happening if it would improve patient services in other areas of need.

Mr Burns: I am grateful to the right hon. Gentleman. I can give him a straightforward answer. Nothing in the Bill will stop the improvement and advancement of cancer care.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): Will the Minister give way?

Mr Burns: No, I will not give way. I argue strongly that the content of the Bill will enhance not only cancer care, but other health care because of the way in which it liberates the NHS. I also say to the right hon. Gentleman that tremendous work has developed, improved and enhanced cancer care through the cancer networks and that will continue beyond the Bill. There is no reason why it should not. I will quit while I am ahead, and I urge the hon. Member for Islington South and Finsbury to withdraw her amendments. If she does not, I hope that my hon. Friends will join me in opposing them.

1.45 pm

Emily Thornberry: Any possibility of my withdrawing the amendments has definitely had the door closed on it as a result of the Minister's contribution. He began with what I cannot describe as anything other than a free market, red in tooth and claw description of patients and doctors making decisions, with that being a way of improving the health service—fairly extraordinary—and then moved on to nothing short of a bland—[*Interruption.*] I am being prompted with “trite”, although perhaps that is unfair—

Grahame M. Morris: Diatribe.

Emily Thornberry: “Diatribe” would be a good word—“trite” might be too unkind, but it is close.

Who can disagree with phrases such as local needs needing to drive local decisions? Everyone thinks local needs should drive local decisions, but what we want to know is, if the system is to be changed, what will it look like? That is our difficulty.

The hon. Member for Winchester tells us with confidence that the current chief executive of the national health service said in evidence that there will be some form of regional bodies, but we hear from the Minister that that simply will not happen.

Mr Brine: What I said in my question to the hon. Member for Pontypridd, which he reiterated in his answer—it is a matter of public record—is that having a form of regional reach by the national commissioning board is very different from having a structure for the PCTs and SHAs costing £5.1 billion a year from the NHS budget. If the Opposition wish to continue carrying a placard saying “Save the SHAs, Save the PCTs”, then, as I said on Second Reading, happy days!

Emily Thornberry: Let me put it in a different way. It is our duty to scrutinise this legislation, but we have still not had any straight answers to an obvious question.

As I said, the King's Fund is not no one. It is talking about difficulties with such things as cancer, heart or stroke treatments, which will not be done as effectively and as well as they could be without the regional structures. The Minister I think said that there is no way we will spare them but, it would seem from the Bill, that the NHS commissioning board will be perfectly able to develop them if it so wishes—the hon. Gentleman is welcome to intervene if I am wrong about his interpretation.

If the national commissioning board in its and Sir David's wisdom should decide that there ought to be some form of regional board, we are talking about a new form of

strategic health authority. How can we be charged with the job of scrutinising the changes to the national health service? All the work on the democratic accountability of the various bodies, and all the time we have spent discussing democratic accountability and the patient's voice—listening to the public, and “no decision about me without me”—and yet through the back door and even though we pass this legislation, suddenly Sir David Nicholson can decide to develop all these strategic health authorities. Plonk! They would arrive with no democratic accountability, because they will not have directly developed from the Bill.

The Minister laughs, but the issue is serious. As the hon. Member for Southport said, to make the changes in such a way is nothing short of risky. The Government should not play games or take unnecessary risks when it comes to the national health service. [*Interruption.*] If the Minister wishes to correct anything I have said, he is welcome to intervene and do so, but as he does not seem to wish to, I assume that what will be in *Hansard* is accurate and that that is what might happen because of the Bill. We might, therefore, develop some form of regional structure without any democratic accountability beyond that placed on the national commissioning board.

Mr Burns *indicated dissent.*

Emily Thornberry: If the Minister wishes to do more than shake his head, I suggest he gets to his feet and explains whether he can guarantee that no regional structures will be developed as a result of the legislation. Thank you—he has not risen.

Nick de Bois: The hon. Lady argues with great passion, but it is not a simple choice between nothing and a large bureaucratic beast. To choose some words familiar to her party, there is a third way. I urge her not to distort the issue into a choice between absolutely nothing and a great big gigantic beast, which the Labour party seems to be wedded to and which is, I fear, the weakness.

Emily Thornberry: What we are wedded to is scrutinising the Bill and getting some idea of it, so that the public can have some clarity about what the Government are doing to their greatly loved national health service. We are not getting any direct answers, but we are attempting to get them. Yes, I am arguing with passion, because I am getting increasingly frustrated. I am sorry to be so critical, but this is one of the areas in which the Members speaking for the Government must be deliberately avoiding perfectly simple and reasonable questions. We need answers to this because this institution is greatly loved and very important to every single one of us. The Minister has been given a note, so perhaps he would like to give us an answer now. No.

Mr Burns: Hang on. I will. It is all right during the course of the hon. Lady's rant to use rhetorical flourishes to suggest that I am thinking this or not saying that, which—by implication—means that I agree with something else. The fact is that we explained why we do not find her amendments attractive or viable within the structures of a liberated NHS. She does not like the answer and so goes on to these flourishes and rants to cover up the fact that she cannot get her own way.

The Chair: I do not think that was quite the intervention the hon. Lady was expecting, but still.

Emily Thornberry: If that is the best I am going to get, perhaps I will press the matter to a vote.

The Chair: I shall say to the Minister that I do not think that it was Mr Morris's intention to hurt you in any way with his comments. You must be far too thin-skinned to be hurt that easily. I am sure Mr Morris has much stronger weapons than that last one for us to get upset over.

Question put, That the amendment be made:—

The Committee divided: Ayes 9, Noes 11.

Division No. 20]

AYES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

NOES

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

Question accordingly negatived.

Emily Thornberry: I beg to move amendment 165, in clause 19, page 18, line 14, at end insert—

13KA Duty to ensure effective workforce planning

In the exercise of its functions the Board must have regard to—

- (a) the future size and makeup of the workforce needed to staff health services for the purposes of the NHS, and
- (b) the necessity to train and ensure the continual professional development of that workforce.?

I shall try to be brief, but I hope that will not be misinterpreted. We believe the matter to be very important indeed. The amendment is about effective work force planning and our concern that strategic health authorities had a role in work force planning. Without them, it does not look like there will be any work force planning at all. Somebody needs to make decisions about how many doctors and various medical professionals we need, how we educate them and where they go. Strategic health authorities have deaneries responsible for placing students in teaching hospitals, and if that is to go, what they will be replaced with is unclear.

Finally, as we have discussed, the Bill will open up the NHS to the private sector. The implication is that the public sector will shrink a bit as private providers enter, so presumably more of the work force will be employed by the private sector. We are uncertain as to whether private providers will offer any training or teaching as part of their role. The amendment would place a responsibility on the board to work out how many doctors and other health professionals are needed and

what their specialities should be and to ensure that they are properly educated and trained. No deanery or successor bodies will force foundation trusts to make room for training posts as part of the work force. The key questions are who will make the strategic decisions on how many doctors we need and who will force private providers to have teaching posts.

Jeremy Lefroy: The question of training is an important one, particularly in the context of private and other non-NHS providers. From the figures that I have seen, the NHS does something in the region of £4 billion to £5 billion-worth of training a year across the board. It is essential that that level of high-quality training—in which I declare an interest, as my wife teaches in a medical school—continues. It is also extremely important that we have no free riders in the system—people who take the benefit of trained personnel without contributing to the cost.

I notice that there is a provision later in the Bill for Monitor to impose a levy on providers, about which I am sure the Minister will have something to say. It occurred to me that that might be a way in which Monitor will be able to charge providers a training levy, which could be distributed to the bodies that provide training in the NHS so that on the one hand, we secure the income to provide that training, and on the other, we provide those who do the training with the right remuneration for their services. Foundation trusts up and down the country, even down to the providers of primary care, are doing training on a day-by-day basis. Sometimes they are remunerated in full for it, sometimes in part and sometimes not at all. It is extremely important that we have a level playing field if further providers are to enter the system.

Mr Burns: Amendment 165 seeks to confer an additional duty on the board through proposed new section 13KA of the 2006 Act to have regard to the future size and make-up of the work force needed to staff health services in the NHS and the need to provide training and continuing professional development for staff. I have sympathy with the intentions behind the amendment, but there is a good reason, which will become evident, why I cannot accept it.

I agree that it is extremely important that the shape of the NHS work force develops in line with future requirements. It is also important that there continues to be sufficient capacity in the system to provide medical education and training, including opportunities for continuing professional development. Members of the Committee will be aware that the Government are consulting on proposals for developing the health care work force, which includes the issue of deaneries. For that reason, I trust that the hon. Member for Islington South and Finsbury will accept that it would be inappropriate for me to start speculating or seek to pre-judge or influence that process. The consultation will run until 31 March, and its results will be reflected in a second Session Bill. It sets out proposals for a new system driven by patient need, led by health-care providers and underpinned by strong clinical leadership. Health-care providers will be at the centre of planning and development in building the work force in consultation with patients. Their decisions will inform the commission of education and training.

[Mr Simon Burns]

The consultation proposes to establish Health Education England to support health-care providers and offer national oversight of work force planning, education and training. It will be a lean and expert organisation, free from day-to-day political interference. It will provide leadership for effective work force planning and high-quality education and training that supports innovation, value for money, better skills development and security of supply. It will focus on those work force issues, which need to be managed nationally and cannot be delivered by local provider skills networks. It will bring together the interests of health-care providers, the professions, patients and staff.

2 pm

Liz Kendall (Leicester West) (Lab): Will the Minister confirm or give us a sense of what area the skills networks will cover? Will they cover local areas matching those of the commissioning consortia, or regions?

Mr Burns: As I said in relation to the consultation process on that whole area, we are still working on it. It would be premature of me at this stage to start speculating. I would now like to make progress because I do not want to get into a position in which I am being asked a series of questions on issues that are currently out to consultation.

Emily Thornberry: I understand that. My question is much more basic. Will we find ourselves in a situation in which the current structures are abolished before we are clear about what the new structures will be?

Mr Burns: No, we will not. As I said, this is a crucial area, which we take extremely seriously. We do not want a situation in which there is any hiatus.

The White Paper “Equity and excellence: Liberating the NHS” set out our intention for the NHS commissioning board to provide national oversight of health care providers’ funding plans for training and education to check that they reflect its strategic commissioning intentions, with consortia having a similar role locally. The current consultation seeks views on how that could best be achieved. It would therefore be pre-emptive to place a statutory duty on the board in that regard at this stage.

However, the Government will table an amendment that provides reassurance about the role that the commissioning board will play in these matters. Under section 258 of the 2006 Act, the Secretary of State is under a duty to exercise his functions

“so as to secure that there are made available such facilities as he considers are reasonably required by any university which has a medical or dental school, in connection with...clinical teaching”.

The Government amendment to schedule 4 to the Bill will apply the same duty to the board and consortia, to reflect their responsibilities in the future for commissioning the majority of health services.

I hope that hon. Members have found my explanation helpful and I trust that the hon. Member for Islington South and Finsbury will consider withdrawing the amendment.

Emily Thornberry: What the Minister has said is of importance but not sufficient. Clearly, the professions need to much more reassurance than they have heard today, but given that the amendment deals with yet another aspect of the Bill that is being developed as we speak, it may not be appropriate for us to put it to a vote today. Be assured, however, that we will return to the matter. It is clearly of great importance and the professions that have been lobbying us and speaking to us need to be assured about it. I am sure that the Minister is aware of, for example, the letter in *The Guardian* on 23 February in which a number of very senior nurses express huge concern.

We hear what the Minister says about there being no hiatus, but it is not clear when strategic health authorities will be abolished or when other bodies will be put in place instead. We would be grateful for answers to simple questions such as that, as would the professions. As I said, we will return to the matter, but I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment proposed: 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.’.—(*Emily Thornberry.*)

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 21]

AYES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

NOES

Brine, Mr Steve	Lefroy, Jeremy
Burns, rh Mr Simon	Morgan, Nicky
Burstow, Paul	Poulter, Dr Daniel
Byles, Dan	Pugh, John
Crabb, Stephen	Soubry, Anna
de Bois, Nick	Sturdy, Julian

Question accordingly negated.

Mr Burns: I beg to move amendment 93, in clause 19, page 20, line 42, at end insert—

13RA Power to make grants etc.

(1) The Board may make payments by way of grant or loan to a voluntary organisation which provides or arranges for the provision of services which are similar to the services in respect of which the Board has functions.

(2) The payments may be made subject to such terms and conditions as the Board considers appropriate.’.

I do not think I need to detain the Committee long on the amendment, which would allow the board to make payments by way of loans as well as grants to voluntary organisations that provide or arrange for the provision of services similar to those that the board will be responsible for commissioning. The power mirrors

the power that the Secretary of State has now under section 64 of the Health Services and Public Health Act 1968, which is exercised by strategic health authorities and primary care trusts. Equivalent provision is already provided in the Bill for consortia under new section 14T of the 2006 Act, inserted by clause 19. The voluntary sector has an important role to play in health care, both in provision of services and support to patients and their families and carers. It is right that the commissioning board is able to provide funding to support them in this work.

Mr Barron: I want to make a brief point, using a hypothetical situation. Let us say that a hospice is taking over palliative care provision where the current service is being supplied by the NHS VAT-free. Will the Minister have a word with Treasury Ministers to see whether they consider that the voluntary sector provision should also be VAT-free?

Mr Burns: That may have been a small intervention, but I got the message. I have fully twigged its significance and can see the potential for a can of worms to open before me. I cannot give any commitment and I do not think that the right hon. Gentleman would expect me to, but I will certainly reflect on what he said and I will make some enquiries about the issue in its generality. I choose my words carefully, so that nobody seeks to misrepresent what I have just said.

The board may also want to fund work that will assist in effectively commissioning services: for example, the board may provide funding to voluntary organisations with particular expertise in support for people with rare conditions to guide its approach to commissioning those specialist services. Grants and loans of that sort will support innovation and vibrancy in the health sector, and we want to encourage them. I strongly commend the amendment to the Committee.

Amendment 93 agreed to.

Emily Thornberry: I beg to move amendment 152, in clause 19, page 21, line 24, at end insert—

13TA Contractors

(1) Where the Board enters into a contractual arrangement to exercise its functions with a person other than—

- (a) its members,
- (b) members of its committees or sub-committees,
- (c) its employees,
- (d) a Special Health Authority, or
- (e) a commissioning consortium,

it shall include provision in the contract that applies the duties of the Board under—

- (i) the Freedom of Information Act 2000;
- (ii) the Equality Act 2010; and
- (iii) any requirements, direction or Regulations from the Secretary of State relating to remuneration of employees or publication of prescribed information relating to the remuneration of employees

to that person in so far as they are exercising the functions of the Board or assisting the Board in the exercise of its functions.

(2) The Secretary of State may issue guidance on the Board's duty under subsection (1).

13TB Duty to promote and uphold the NHS Constitution

The Board must ensure that all commissioners and providers of services for the purpose of the NHS abide by the NHS Constitution, as legislated for in section 1 of the Health Act 2009.

13TC Duty to ensure effective workforce planning

The Board must ensure that all commissioners and providers of services for the purpose of the NHS follow any relevant provisions of the NHS Constitution, as defined by section 1 of the Health Act 2009.

The amendment would ensure that, if a board chooses to outsource any of its functions to external bodies, the same duties to abide by the Freedom of Information Act 2000 and the Equality Act 2010 would be included in any contract with the outsourcing company. It would ensure that those staff employed by outsources are treated fairly. The duty to uphold the constitution is covered under schedule 5 to the Bill, but the amendment would go further by suggesting that the board should have a duty to promote actively the constitution among commissioners and providers and that the board should be the body to enforce those bodies abiding by the constitution.

The Minister of State, Department of Health (Paul Burstow): Amendment 152 would insert three new sections into new chapter A1 of the 2006 Act, inserted by clause 19. Proposed new section 13TA stems from the concern to ensure that any body with which the NHS commissioning board subcontracts the exercise of the functions is subject to the same duties as the board itself. It would require the duties of the board under the Freedom of Information Act 2000 and the Equality Act 2010 respectively to apply to any person with whom the board enters into a contract. I hope that I can reassure Opposition Members on those points.

The Equality Act's prohibition on discrimination by employers or service providers applies to all bodies, whether public or private, including any contractor of the board. Under section 149 of the Act, it is already the case that the public sector equality duty applies to a person who is not a public authority, but who exercises functions of a public nature. As the functions of the board are clearly functions of a public nature, the duty applies to any person exercising the board's functions. The duty would not apply to a contractor who is simply providing services to the board, but that does not remove the board's obligation under the Act: the board must continue to have regard to the matters set out under section 149 and ensure that they are taken into account in the exercise of its functions, whether it is being assisted in those tasks by its own staff or a contractor. The board must ensure that any arrangements it has with a contractor are consistent with its equalities duties.

Under the Equalities Act 2010, the equality duty comes into force on 6 April and the ban on age discrimination comes into force from 2012. The Government Equalities Office has today launched a consultation on how the age discrimination ban would apply under the Act. On behalf of the Department of Health, I announced today that we want to send a clear signal to all parts of the NHS that age discrimination is never acceptable. As part of our commitment to personal, fair and diverse service that protects patients' dignity and ensures that they all receive the best possible treatment

[Paul Burstow]

regardless of their age, the Department for Health will not seek any exemptions from the Act. Any decisions will have to be clinically evidenced when it comes to using age as a basis for determining those services.

The position in respect of the Freedom of Information Act is different from that in respect of the board's public sector equality duty; however, the duty under that Act to respond to requests for information would apply to the board regardless of what arrangements it makes for the exercise of its functions. When the NHS commissioning board entered into a contract with another person to exercise its functions on its behalf, it would remain responsible for ensuring compliance with those duties. At present, contracts commonly include provisions to ensure that contractors provide any information that might be needed by public bodies to respond to requests under the Freedom of Information Act.

New section 13TA(1)(c), which the amendment would insert into the 2006 Act, reflects the zig-zaggy nature of Opposition amendments. Many would reduce the role of the Secretary of State in the conduct of the NHS, while others would do the exact opposite and extend micro-management still further. It is not clear whether those are amendments that are intended to improve the Bill, or the sort that the hon. Member for Islington South and Finsbury described this morning as intended to undermine it.

New section 13TA(1)(c) would require contracts to contain requirements on staff remuneration that were set out by the Secretary of State, presumably to ensure that levels of pay that may be received by staff working for contractors are consistent with those paid to employees of the board. When entering into contracts, it would be incumbent on the board to engage external resources following an open and transparent procurement process. However, as I said at the start, as long as it complies with established procurement law, the board must be free to decide what represents the most effective means of meeting its statutory responsibilities. I certainly cannot agree that we should introduce powers to enable the Secretary of State to set the levels of remuneration and conditions of employment that private or voluntary sector bodies choose to offer their staff.

2.15 pm

On the duties contained in proposed new sections 13TB and 13TC, we are equally unshakeably committed to the principles set out in the NHS constitution. Schedule 5 to the Bill will amend the Health Act 2009 so that the NHS commissioning board and commissioning consortia will have a duty to have regard to the NHS constitution. As my right hon. Friend and fellow Minister has said in previous debates, we are clear that the commissioning board will have a duty to proselytise and promote the NHS constitution. Providers of NHS services are already subject to those duties, as section 2 of the Health Act 2009 ensures that those providers have to have regard to the NHS constitution.

I hope that I have given the hon. Member for Islington South and Finsbury and others the assurances they seek. If not, and the amendment is pressed to a vote, I urge my hon. Friends to oppose it.

Emily Thornberry: I am grateful to the Minister for his comments, which have answered most of the questions raised. We may have further questions about proposed new section 13TA, but if so we will come back to that at another stage.

Let me say in passing, it will be clear when we are trying to undermine the Bill and when we are trying to help. I am sure that the Minister is intelligent enough to know the difference. The amendment was one with which we were attempting to help.

I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

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

Emily Thornberry: This is a major clause, and we are against it being part of the Bill. We are against it because we want to undermine the Bill and because we think the provision will undermine the national health service. It is a big change, and not a positive one. We are concerned about how accountable the NHS commissioning board will be to patients, the public and Parliament, and about how autonomous and independent it will be from the Secretary of State. We do not understand what the relationship will be between it and regional bodies, and we have not had adequate answers on that. We are concerned about what will happen to training if regional bodies are got rid of. The clause throws up more questions than we have had answers, and it is too important to be allowed to pass as it stands.

Liz Kendall: I shall explore the NHS commissioning board's responsibilities for price setting. I do not want to stray beyond the scope of the clause, but we know that the NHS commissioning board has a central role in price setting, not only from the White Paper, but from Sir David Nicholson's evidence to the Committee. As hon. Members will remember, Sir David said that

"the commissioning board sets the pricing system...but the economic regulator will set...the number... The legislation cleverly"—

his word, not mine—

"locks us together to ensure that you get agreement on that, so it is very much a joint position".

I asked him:

"So you have to jointly agree the price?"—[*Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 7, Q9-10.*]

Sir David replied, "Yes."

That is why it is relevant to note formally today that the Government have made a highly welcome U-turn on their proposals to allow price competition. Everybody who gave evidence to the Committee—from those who very much favour the Government's proposals, such as Professor Julian Le Grand, to those who very much oppose them, particularly the trade unions, and all those in between, such as the Royal College of Nursing, the British Medical Association, other professional bodies, patient groups, academics and think-tanks—said with one voice that allowing competition on price reduces the quality of care, as all the evidence shows, and could allow a race to the bottom.

Hon. Members from both sides of the Committee were grateful to receive the letter from both Ministers in which the Government agreed to table amendments

such that Monitor will not be allowed to set a maximum price—in other words, to allow others to undercut that price to secure contracts—and to clarify that it will not be able to set differential prices on the grounds of who owns a service, whether to allow the private sector to offer lower prices than the maximum to get into the market, or to allow the voluntary or public sector to do the same.

The Minister predicted what he thought I would say on Tuesday, so I hope he will not mind if I do the same to him today. The letter states that it was never the Government's intention

“to introduce a...policy of price competition”.

If so, why have they tabled amendments to remove from the Bill measures that would have allowed that to happen? In addition, I alert hon. Members to a speech given by the Secretary of State for Health in 2005, when he was shadow Health Secretary. He gave that speech, “The future of health and public service regulation”, to the NHS Confederation. If anyone is in doubt that the current Secretary of State always sought to introduce price competition in the national health service, they may like to read it. I shall read out a couple of key quotes. The right hon. Gentleman said:

“I believe it will be right and secure to permit price competition... It will enable GPs, if they are budget holders, to be able to purchase actively, including negotiating offers on quality or price that help them better to utilise their budget for their patients.”

He referred to evidence from the United States, saying:

“The experience of the US suggests that to avoid the inflationary effects of competing on quality alone, purchasers developed managed care organisations”—

in case anyone is not aware, those are usually insurance-based companies—

“enabling the budget-holders to negotiate discounts... There is no doubt that GPs, as budget holders, should develop in this direction, either through locality-based co-operatives, or by contracting with managed care organizations.”

Dan Byles (North Warwickshire) (Con): That is fascinating—a six-year-old speech from a shadow Secretary of State, and none of those words is in the Bill. If we are going to start quoting things that politicians, six years ago, said they might like to see—*[Interruption.]*

The Chair: Order. Let us hear what Members are saying.

Liz Kendall: I quoted that speech not solely because of its relevance to the present question, but because the then shadow Health Secretary went on to refer to introducing an economic regulator into the NHS, as the Bill seeks to do; giving budgets to GPs, which the Bill seeks to do; and setting up an independent board, which the Bill seeks to do. All those points in that speech relate to the Bill, which is why I am quoting it.

Dan Byles: At the risk of contradicting what I have just said, that is fascinating because only a few weeks ago the Opposition were saying that all these reforms fell out of the sky and that we had not said anything about them before. Now the hon. Lady says that they were being mooted six years ago.

Liz Kendall: What we said was that none of this was in the Conservative party's manifesto. The hon. Gentleman will find no reference to an independent economic regulator in his party's manifesto, and none to wanting to have price competition.

I am sure that we will return to these debates, but at this stage, in the spirit of moving forward, let me say that I am glad that the Government have listened to the concerns of patients, public and staff. I hope they will continue to do so throughout the rest of Committee stage.

Mr Burns: So that we can make progress and because I am simply correcting the record after the little wander in the woods by the hon. Member for Leicester West, let me make it clear in advance that I will not accept any interventions as I read the letter that I and my fellow Minister of State sent to members of the Committee today.

“We are writing to notify fellow Committee Members of amendments we have today tabled regarding Monitor's function to set prices, and how this relates to competition. As colleagues are aware, we have already spent a significant amount of Committee time discussing the Bill's provisions on competition. Unfortunately, not all of these discussions have been fully informed of the Government's intentions in this area. The amendments tabled today are designed to clarify our policy and close loopholes left by the previous Government. The amendments, if accepted, would:

- a. clarify our position on the tariff by removing the ability of Monitor to set maximum prices; and
- b. clarify that Monitor is not able to set differential prices on grounds of ownership.

Our policy on competition in the NHS is, and always has been, that it should be based on quality rather than price. We are fully aware of the academic evidence in this area; indeed, it was the Department that commissioned some of the key studies, for example the recent work led by Professor Carol Propper.

Under the existing legislative framework, Ministers have had complete freedom to introduce price competition should they so wish; the Bill as currently drafted continues to allow for the possibility of tariffs to be set as maximum prices, rather than set solely as fixed prices.

However, while the Government's intention not to introduce a general policy of price competition is clear, it is none the less a possibility that Monitor could in future seek to pursue a different approach, subject to agreement with the NHS Commissioning Board. This is not a scenario that we have considered to be at all likely; and in the Operating Framework, we made clear a range of safeguards and conditions that had to be met before prices could be treated as a maximum. However, to ensure clarity in this area, the amendments we have laid will remove the possibility of Monitor setting maximum prices.

The Bill also allows for some further national flexibility in price setting. Monitor can specify different prices depending on whether the service is designated (under Monitor's powers to preserve continuity of services), or due to different descriptions of the provider. The latter power was designed to allow prices to adequately reflect the higher unavoidable costs some providers face compared with others; for example, the differential costs based on location. It is important that we maintain such flexibility in the future.

It has never been the Government's intention to use this power to pay certain providers an increased tariff by virtue of their ownership status. We are not, for example, at all in favour of the approach adopted under the previous Government's Independent Sector Treatment Centre (ISTC) programme of paying providers a higher tariff.

However, this is another area where our proposals have been misinterpreted. To put the matter beyond doubt, the amendments laid remove Monitor's ability to vary prices by reference to whether a provider is in public or private ownership.

[Mr Simon Burns]

We look forward to debating these amendments with colleagues at the appropriate moment in Committee proceedings.”

Mr Barron: I am surprised and dismayed that the Minister was not prepared to take interventions. His colleague, the hon. Member for North Warwickshire, said that one of my hon. Friends was quoting from a speech from six years ago. I wanted to ask the Minister, while he was on his feet, exactly what he meant with his comments in a BBC “Newsnight” programme this January. He said:

“It is going to be a genuine market. It is going to be genuine competition.”

Mr Burns: I can help the right hon. Gentleman there. What I meant was what I have meant all along, as I mentioned on Second Reading even before that. I believe in a genuine level playing field of competition—but competition of quality, not price.

2.30 pm

Owen Smith: I have three questions for the Minister on different aspects of the clause. One is about the mandate. On page 15, lines 32 to 34, the Bill currently states:

“The Secretary of State may not specify in the mandate an objective...about the exercise of the Board’s functions in relation to only one commissioning consortium.”

I understand the rationale—to mitigate political interference by the Secretary of State—but the question I pose is whether the provision is wise. Given the variation in the size of GP consortia, with a single consortium responsible for 600,000 or more patients or with different consortia banded together as suggested in the documents leaked this week from Integrated Health Partners, will the Minister reconsider whether it is wise for the Secretary of State not to be able to interfere in respect of a single consortium, when it might cover millions of patients?

My second point is about information and relates to page 18, lines 40 and 41, where proposed new section 13M states:

“The Board must establish and operate systems for collecting and analysing information”

regarding patient safety. In essence, that is what Dr Foster Health does for PCTs, SHAs and trusts now. Is it proposed that the board will replicate the functions of Dr Foster? If so, how many people is it likely to employ, and at what cost? Proposed new section 13M(2) then states that the board will make such information

“available to such persons as the Board considers appropriate.”

I ask the Minister to consider amending the subsection, to suggest that the board publish information that relates to patient safety. As drafted, the Bill begs the question of how the board can properly determine who the patients or people are to whom the board ought to make available information about patient safety. Clearly, such information ought to be published, as is the case currently.

My third point is about Wales, which gets a first mention on page 18 of the Bill, from line 5, in proposed new section 13K—

“the Board must have regard to the likely impact of”

commissioning decisions

“on the provision of health services to persons who reside in”

border areas of Wales and Scotland close to England. For the board to “have regard” is not sufficient. It should have a duty to consult with the National Assembly for Wales if deciding about specialist services that straddle the border. The question of specialist services straddling the border is not addressed anywhere else in the Bill. If I am wrong about that, I am happy for the Minister to correct me.

Debbie Abrahams: I want to make a few points about this important clause that have not been made already.

The clause is the basis for the Government’s repealing the current duty of the Secretary of State to provide a comprehensive and universal service. The Minister talked about Labour zig-zagging, but the Government’s argument—on that basis—is that the board ensures that the NHS is free from political control. However, proposed new section 13A(4)(b) allows

“any requirements the Secretary of State considers it necessary to impose on the Board”

to be specified in the mandate.

In spite of Government assurances, there is still real concern about the compulsion to use private health care providers even if they do not add value, quality or capacity to the NHS. Although we welcome the U-turn on price competition, the *Health Service Journal*, for example, has reported seeing Government documents spelling out in quite a lot of detail the nature and pace of the change needed and intended around NHS commissioning, and revealing how private health care providers are being courted. I think the Government are the pot calling the kettle black on the issue.

We had a long debate on patients and the public, so I do not want to go into that in any great detail, other than to express my disappointment that amendment 135 was not accepted. Talking about health inequalities, to which I want to move on in a minute, if we do not use professionals to access hard-to-reach groups, we might have the unintended consequence of marginalising people who are already finding it difficult to access health care.

Regarding proposed new section 13F of the 2006 Act, I say again that if we are serious about reducing health inequalities, we should focus on upstream, national socio-economic policy and not just look at the local level. In some areas, there is evidence that that accounts for 70% of existing health inequalities. However, inequitable access to health care is also a key determinant of health inequalities.

Will the Minister consider specifying in the mandate the tools that we should be using, such as the health equity audit and the health equality impact assessment, as the World Health Organisation and the Marmot review of health inequalities do, to ensure that we do not further exacerbate inequalities?

My final remarks relate to provisions that I believe at least contravene the culture and principles of the NHS constitution—at worst, they are unethical. Proposed new section 13H is about the board making bonus payments as prizes—a new game show, possibly—to promote innovation in the provision of health services. That fails to understand the NHS ethos and what should drive the NHS. This is our NHS, not an investment bank. Linked to that is proposed new section 13R and

the board's power to generate income. The power is being introduced under Health and Medicines Act 1988, and again it flies in the face of the principle enshrined in the NHS constitution that treatment and care should be free. The power would leave that principle open to abuse.

Grahame M. Morris: I will be brief, as many of the points have already been covered. I refer to the annual mandate in the clause, where I think there is a missed opportunity for Parliament to play a greater scrutiny role. The mandate will be a series of objectives that the Secretary of State thinks the board should work to achieve and other requirements that he considers necessary to ensure that those objectives are met.

Perhaps we will refer to that as “the Chelmsford mandate” in setting the programme. Whatever we call it, I think that we as parliamentarians should have the opportunity to hold the Secretary of State to account and to approve that mandate, or otherwise—not least because the current duty on the Secretary of State to provide or secure the provision of services for the health service is being removed. We on this side of the Committee are genuinely concerned that there will be a democratic deficit.

Parliamentary approval for the annual mandate, as was proposed in amendment 111, which was rejected, would have allowed Parliament an opportunity to scrutinise the Secretary of State's objectives and add further objectives for the commissioning board. Although I am a new Member of Parliament, I understand that it has always been customary for MPs to lobby Ministers for changes in the health service that would benefit their constituents. As the mandate seems to be one of the few opportunities that we, or even the Secretary of State, would have to influence progress in the NHS, I regret that we have not been given the opportunity to do so. The mandate may also relate to future financial years, if longer-term objectives are set. Parliamentary approval would allow a new Parliament to set out a different course for the board in future. That might have partially precipitated the Ministers' letter.

There is a clear evidence base for less reliance on the market and for more co-operation and well-managed services. Those arguments are growing, and as my hon. Friend the Member for Islington South and Finsbury said, the King's Fund today released a report stating that

“relying on market forces alone will not deliver the changes needed, with the risk that the quality of patient care will deteriorate in hospitals faced with large financial deficits.”

In my mind, the wholesale removal of elected representatives playing a role in standing up for their constituents and setting out the general direction of the NHS is unnecessary. We will not be able to approve the mandate in Parliament; it will simply be reported to us. I support the points made by my hon. Friends.

Question put. That the clause, as amended, stand part of the Bill.

The Committee divided: Ayes 12, Noes 9.

Division No. 22]

AYES

Brine, Mr Steve	Burstow, Paul
Burns, rh Mr Simon	Byles, Dan

Crabb, Stephen	Poulter, Dr Daniel
de Bois, Nick	Pugh, John
Lefroy, Jeremy	Soubry, Anna
Morgan, Nicky	Sturdy, Julian

NOES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

Question accordingly agreed to.

Clause 19, as amended, ordered to stand part of the Bill.

Clause 20

FINANCIAL ARRANGEMENTS FOR THE BOARD

Emily Thornberry: I beg to move amendment 118, in clause 20, page 23, line 40, at end insert—

“(2A) Any variations agreed shall be reported to Parliament.”.

We now move to the financial arrangements and use of resources by the board. Proposed new section 223C states:

“The Secretary of State may direct that the Board's use of resources in a financial year must not exceed a specified amount”.

Subsection (2) states that the Secretary of State

“may vary the specified amount only if—

(a) the Board agrees to the change, or

(b) the Secretary of State considers that there are exceptional circumstances that make the variation necessary.”

Clearly, such power is worrying. I will be interested to hear what the Minister says, but the provisions seem to mean that the Secretary of State can agree an amount that the NHS commissioning board is to have for the year, and then halfway through the year can say, “Sorry, we have to decided to pay off the deficit even harder and faster, and you can only have half the money that we said you could have. It is an exceptional circumstance and therefore the variation is necessary.”

The amendment would ensure that any variation agreed would be reported to Parliament to ensure some form of parliamentary accountability. It could be in the form of an oral or ministerial statement, with time allocated for a debate. Given the scale and nature of the reforms, it is no wonder that the Secretary of State wishes to protect himself with this particular clause. It will be interesting to hear from the Minister what he thinks the Secretary of State is afraid of.

Mr Burns: If it helps the hon. Lady, I shall start by saying that my right hon. Friend the Secretary of State is not afraid of anything. He has no reason to be afraid of anything.

Clause 20 deals with the financial arrangements for the NHS commissioning board. Broadly, the clause sets out how the Secretary of State would allocate funds to the NHS commissioning board for it to carry out its functions. It includes commissioning the services for which it will be directly responsible and its allocation of funds to consortia.

[Mr Simon Burns]

The Secretary of State is required to specify annually in the mandate to the board the amount of funding that will be allocated to the board for that year under proposed new section 223B. The board will then be under a duty in proposed new section 223D to ensure that its expenditure does not exceed the total amount allocated to it by the Secretary of State and any other income it receives. That, in effect, is a cash limit—a limit on the total amount of cash that may be spent by the board in that year.

Under proposed new section 223C, the Secretary of State may also place a limit on the amount of resources that the board can make use of in a single financial year. That is the board's resource limit.

2.45 pm

The system of setting not only a cash limit on expenditure by the commissioning board, but also a limit on use of resources, reflects the system for controlling Government resources under the Government Resources and Accounts Act 2000. I am sure that all hon. Members will remember that Act, which was passed by the previous Government. The powers are similar to those that apply under the current system.

The Bill departs from the current arrangements in that it will reduce the scope for the Secretary of State to amend those limits once they are set, and it removes the broad powers to direct how those funds are used. That change will introduce far greater stability and transparency to the system and give the commissioning board the autonomy to make decisions about how best to allocate resources in order for it to improve health outcomes for patients. In future, the Secretary of State will be able to make a new allotment to the board, or vary its resource limit, only with the board's agreement or if there are what he considers to be exceptional circumstances.

The amendment would require any change to the board's resource limit under proposed new section 223C to be reported to Parliament. It is right that the arrangements should be transparent, but the Bill has already provided for that. As I have said, the annual mandate will set out the amount of money allocated to the board for that financial year, and its resource limit.

Under proposed new section 13B, inserted by clause 19,

“If the Secretary of State makes a new allotment under section 223B(3) or varies the Board's resource allocation under section 223C(2), the Secretary of State must revise the mandate accordingly.”

Any revision made to the mandate would require it to be republished, as amended, and laid before Parliament along with an explanation of the reason for the change. The provisions already amply cover what the amendment seeks to achieve. With that knowledge, the hon. Lady will be reassured, I hope, and will consider withdrawing the amendment.

The hon. Lady specifically raised why the Secretary of State might change the amount allocated to the board in year. The current powers allow the Secretary of State to change the funding or resource limits whenever he likes. The Bill introduces a limit to that for the first time. There might be circumstances in which a Secretary of State wanted to increase the funding for a variety of reasons. I hope that that helps the hon. Lady.

Emily Thornberry: I want the Minister to spell the issue out for us. He says that a report will be laid before Parliament. Will that be similar to or the same as an oral or written ministerial statement?

Mr Burns: It will be laid before Parliament in the same way as other documents are laid, day after day. There would be nothing to stop a Secretary of State, if they wished, accompanying the laying of that document with a written or oral ministerial statement, if the circumstances demanded it. That would be determined by the reason for making such changes.

Emily Thornberry: So there would not automatically be an allotted time for a separate debate if it were laid before Parliament.

Mr Burns: No, but this goes back to a number of debates that we have had, because the measure gives far greater powers of accountability to Parliament over the national health service. The document will be laid before Parliament, which means that a debate can be initiated by the Government, the Opposition, or individual Members of Parliament through the use of one-and-a-half-hour debates or half-hour adjournment debates. That accountability is far greater than that which we currently enjoy.

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

Amendment, by leave, withdrawn.

The Chair: I must say that the Minister has said a brave thing on behalf of the Secretary of State—that he was afraid of nothing. The Secretary of State has obviously never shared a flat with the hon. Member for Colchester (Bob Russell).

Nick de Bois: That is on the record.

The Chair: I have, and it scared me. Please do not repeat that to him.

Mr Burns: Your secret is safe with us.

The Chair: I am sure it is.

Jeremy Lefroy: I beg to move amendment 107, in clause 20, page 24, line 32, at end insert—

‘(3) To ensure the equitable provision of services, the Board must ensure that the per capita resources allocated to each consortium must be no less than 95 per cent. of the average per capita resources allocated for England.’

The purpose of the amendment is to raise the question of the finance of commissioning, and particularly of the consortia. Approximately 80% of commissioning expenditure will be by consortia, but their budgets will effectively be set by the NHS commissioning board. According to Sir David Nicholson, one of the purposes of the board will be to make financial allocations to consortia and set the financial strategy for the commissioning system. It therefore has an extremely important role.

How budgets are set will be absolutely crucial to the success of consortia. However good a consortium is, it will not survive if its budget is inadequate to meet the needs of the population that it serves. In 2006, in my constituency, services were cut in Stafford hospital and its trust to meet a £10 million shortfall. Although such a factor was not by any stretch of the imagination the only reason for the problems, it was certainly a contributory factor. As I shall show, one of the main reasons was that health services in Staffordshire had been underfunded through the local primary care trust.

Currently, funding is allocated to PCTs by a complex funding formula, and I would like the Minister to say whether that will continue. The formula determines the share of resources that a PCT currently—and perhaps a consortium in future—is entitled to, based on population, the local cost of health service provision, and the levels of health care need and health inequality. Will that continue to be the case, or will there be a change? I will comment on that later.

Mr Barron: One principle of the Bill is to reduce inequalities of provision in the national health service. Does the amendment fit well with that?

Jeremy Lefroy: I think it does, and I was about to explain why. The disparities in funding per caput are already great. For instance, in the PCT covering the constituency of the hon. Member for Islington South and Finsbury, where I had the pleasure of growing up, it is £2,230 a year. In my South Staffordshire PCT, it is £1,460, which is a huge difference. I accept that the money going to a PCT is not the entire quantum of health funding for people in an area, but it was by far the largest element of that last year; in the financial year 2010-11, it accounts for £84 billion of the NHS budget.

I fully accept that there are reasons for that difference—higher staff costs, particularly in London, and greater deprivation in many areas, which was perhaps what the right hon. Member for Rother Valley referred to. But I find it difficult to understand how so great a difference can be justified. I have heard it argued that the greatest determinant of the cost of the health service is age. I am not sure whether that is fully reflected in the formula, or whether the formula will be adjusted as a result, for instance, of this year's census.

Grahame M. Morris: I do not know whether the hon. Gentleman's comment about the greatest determinant of ill health is a matter of opinion or a statement of fact, but he must recognise that there is an association between chronic ill health and heavy industries such as coal mining and steel production. They have a consequential effect on people's health as they get older, which has a consequential effect on demand for primary and secondary health care services.

Jeremy Lefroy: I thank the hon. Gentleman for his intervention. I fully agree with that. I am not saying that those things are not a determinant of the costs of health services; clearly they are major determinants, and I fully accept that. However, I think there are one or two others that have not been fully taken into account. In light of a growing and ageing population and the age profile of different parts of the country, they need to be taken into account, although I am not stating that that is necessarily how we should go forward.

The second reason is related to disparities between consortia. At the level of SHAs, the lowest allocation per head is £1,450 and the highest is about £1,850. That is a smaller disparity than at the level of PCTs, where it goes from between £1,400—or even possibly lower—up to £2,200. As populations become smaller, going down from SHA to PCT, the disparity gets wider. Therefore, when we introduce consortia, the disparities are likely to be even greater, as we will have smaller populations within the consortia than we currently do within PCTs.

There are one or two places—Stoke-on-Trent, for instance—where the PCT will become the consortium, but in most cases we are talking about two, three, four or even five consortia within each PCT area. That would push funding for other areas down even lower. I have seen figures that suggest that the population of some consortia could receive overall funding that is as little as half of others', but that remains to be seen. With salary levels throughout the health-care professions being similar across the country, particularly in the NHS outside London, I see the potential for considerable unfairness. That is one of the greatest single risks facing consortia, which is why I wish to raise it at this stage of our proceedings, which are the first appropriate point.

I believe that the risk may be countered in a number of ways, and I look forward to the Minister's comments. First, the formula used by the commissioning board to allocate funding should be made absolutely clear so that it can be checked and, if necessary, challenged if the consortium thinks that it is not appropriate.

Secondly, as per my amendment—this is simply a probing amendment, and I have no wish to press it to a vote—there should be a floor to per capita allocation. That would mean that no consortium could receive less than a certain level of per capita funding. I fully accept that there needs to be a variation in funding. As the hon. Member for Easington pointed out, some areas of the country have good reasons to get higher funding than other places. No one, least of all me, is suggesting that everyone throughout England should get exactly the same funding allocation. That would be ludicrous.

Thirdly, consortia should have the opportunity to participate in risk pooling. For example—this may or may not work—we could consider how risk pooling might be carried out through setting up a captive insurer within the national commissioning board that would protect a consortium from major events, such as local outbreaks of disease, that would have a dramatic effect on it, particularly if the numbers within the consortium were small.

I tabled the amendment to ensure that consortia can be confident that if they run their affairs to the highest standards and with the best use of resources, they have no reason to fear that inappropriate budget setting based on insufficient analysis will result in either extreme financial stress or even failure.

Mr Burns: I fully understand where my hon. Friend is coming from in tabling the amendment, and I listened with care and interest to the valid points he makes. I reassure him that the Government are absolutely committed to the principles of localism and of clinically led commissioning, passing funding and responsibility for decisions as close to the patient as possible. He is absolutely right in suggesting that the majority of resources should

[Mr Simon Burns]

be allocated to consortia to commission services locally. Having said that, I think that there is a risk in trying to place in the Bill a fixed figure on the proportion the board can allocate to each consortium. That is because I think it is equally important that decisions over the allocation of resources should be fair and transparent and free of political motivations. That is why we are establishing an independent commissioning board that will be responsible for the allocation of NHS resources to consortia, free of interference from politicians.

3 pm

The White Paper indicated that the allocation should be on the basis of seeking to secure equivalent access to NHS services relative to the prospective burden of disease and disability. The board will therefore need to consider its duty under new section 13F of the 2006 Act to have regard to the move to reduce inequalities between patients with respect to their ability to access health services when exercising its functions, including allocating functions to consortia.

The NHS Confederation has expressed its concern that any firm ministerial commitment to an essentially arbitrary figure would cause real problems for both the Department and commissioning consortia when funding allocations are being determined. I think we should be mindful of that. It is important to remember that the board will be working within a fixed budget, so setting a minimum allocation that is relative to the average would reduce the board's ability to set a higher allocation where it is needed. We would not want to put the board in a position where it had no choice but to cut resources in some areas, undermining the stability of health care provision in those areas.

The weighted capitation formula has to take account of the fact that the cost of commissioning for providing health care services is not the same in every part of the country, owing to the impact of market forces on local costs. The resources needed to secure equivalent access can vary for many legitimate reasons. My hon. Friend is right that that can lead to variations in the funding that PCTs receive. Older populations, as my hon. Friend acknowledges, have significantly greater health needs. Levels of deprivation are also taken into account, along with local unavoidable cost differences reflected in the market forces factor.

The process for developing the allocations formula is therefore extraordinarily complex, and it is not necessarily the case that an average allocation represents a fair one. That is why I think the commissioning board will be best placed to make such decisions. No doubt, it will seek independent advice, as we currently do through the Advisory Committee on Resource Allocation.

My hon. Friend also mentioned risk pooling. He is right that it will be an important safeguard for consortia to have the ability to pool their resources. Indeed, new section 14Q, inserted into the 2006 Act by clause 22, allows consortia to establish and maintain pooled funds. New section 13Q gives the commissioning board the same power to establish pooled funds with one or more consortia.

In addition, the commissioning board will be able to establish a contingency fund under new section 223G, inserted by clause 20. The contingency fund would provide

an additional backstop to ensure that the health system is able to deal with unanticipated demand. It would mean patients continue to receive the services they need in the event that a consortium is unable to meet unexpected costs from its existing budget. The commissioning board could also need to draw on the fund in the event that it faces pressures in demand for specialised services, for example, which are often the most expensive.

The fact that the board will need to have the ability to determine what level of resource should be put into a contingency fund is a further reason why I think it would cause difficulties to fix a formula for allocations in legislation. The commissioning board will need to be able to make a judgment on that and on the level of resource it will need to commission the services for which it will be responsible. The exception to that is that the Secretary of State will retain a role in determining how much of the total allocation may be spent by the board and consortia on prescribed matters relating to administration, which will be clearly defined for the first time in regulations. The Secretary of State will also place a cap on the amount the board may spend on administrative matters. Any underspends will be able to be reinvested in services for patients.

Although I sympathise with the concern underlying my hon. Friend's amendment, I do not think it would be appropriate to include a specific provision of that sort in the Bill. I understand his point about the amendment being probing. I hope that my explanation has reassured him.

Mr Barron: I am happy that the hon. Member for Stafford has moved the amendment. I will cover one or two things said by the Minister, but there has been a debate in this country for many years now that our current funding formula is somewhat skewed, often against individual constituencies. I have often heard that case.

The formula is complicated, as the Minister said. It recognises a number of issues, such as age. PCT funding in your constituency, Mr Hancock, probably recognises the fact that the south coast has a lot of elderly people and, quite frankly, weights the funding to reflect that. Indeed, if we look at the profile of users of the national health service, we see we use it in early life and later life; in between, many years go by when we do not use the NHS at all. To a vast extent, it is young children and elderly people suffering from age-related problems who use the health service. The funding formula recognises that fact, and it always has done.

We have had that debate in Parliament for many years. I think that the funding formula not being fair is somewhat of a myth. Let us look at the current allocations, even though the current PCTs might not be exactly replicated by GP consortia, although it looks as though that will be the case in my borough. If we look at this year's figures for the per capita allocation, the top three are: City and Hackney Teaching PCT, whose allocation is more than 36% above the national average; Islington PCT, with more than 36% above; and Liverpool PCT, with more than 30% above. Looking at the bottom ones, at more than 19% less than the national average is Leicestershire County and Rutland PCT; next, at more than 18% less, is Mid-Essex PCT; and then there is Buckinghamshire, at 17% less.

We really have to ask, what are the differences between those six areas? It is quite clear. The bigger need in the top three areas is primarily because they are poorer. Poorer communities carry more of a disease burden. My hon. Friend the Member for Easington mentioned the example of steel and coal areas, which I have represented, and worked and lived in, in one form or another, all my life. Such areas carry major disease burdens related to industry. Look at Rotherham PCT at the moment. There is chronic obstructive pulmonary disease, which comes from people working down coal mines, which I did for a good number of years, but incidence among the female population of the area is far higher than the national average. Why is that? Because it is a poorer area of the country; more C4 and C5-class people work there, and they tend to smoke more cigarettes. As a consequence—well known for decades now—such communities have a bigger need for more money in order to deal with such diseases.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): That is indeed the case in such places. Liverpool PCT, for example, covers four of the most deprived wards, with life expectancy of less than 57. That is why the PCT gets that above-average spend. In Middlesbrough, the 2007 Office for National Statistics census found that Middlehaven ward had the lowest life expectancy of all, at 54.9.

Mr Barron: I do not want to go through the league table, Mr Hancock, and I know you do not want me to either, but my hon. Friend is right. The differences are because of a recognised need. As I said in an intervention, if one of the principles and aims of the Bill is to reduce inequalities in health care provision, we must recognise that those inequalities are present. That is why the funding regimes are as they are.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): The right hon. Gentleman makes a good point about health care inequalities, in particular about COPD—the intrinsic link with poorer areas and a high preponderance in the female population because of smoking. Does he agree that another big problem is that, in some of the poorer areas and deprived parts of the country, people often present to health care facilities very late? That is where a lot of the resources need to be targeted. Another point that has been raised by Conservative Members is that people in other areas, particularly older people, often need health care for a number of years because of chronic conditions. That is the case in Eastbourne, which is a bit more affluent, and that is not necessarily reflected in the funding formula as it stands.

Mr Barron: I think it is. I will not repeat the music hall joke about where Eastbourne is the gateway to, but a lot of elderly people there may have two or three long-term conditions that are expensive to treat and last for many years. Life expectancy is growing all the time. This will be the future. Any funding formula of any commissioning body will have to recognise that. I do not say for one minute that there are no people in Rutland with problems with COPD, but it is the scale of these problems that is the reason why the funding regimes are as they are.

The hon. Gentleman spoke about access to health care and late access. That has been one of my hobby horses for many years. If we looked at the PCT and

then at the ratio of GPs we would find that there are more GPs per head of population in the leafier glades than in poor areas. Indeed, for 60 years, there has never been any direction to say that GPs must go and work in areas where there is a bigger incidence of disease. We have known the disease burden has been there for decades, partly to do with industry and partly to do with culture and lifestyle, but we have never done that.

One of the last things the previous Government did was, in areas such as mine, to open walk-in centres. I can go seven days a week, 12 hours a day to see a GP. I hope that the commissioning board will tackle the restricted nature of most GP surgeries and the lack of them in communities where there is a high disease burden. We have been unable to do that since 1948. The national commissioning board needs to look at commissioning GP services in areas where there is greatest need and to get that early access. We know that with early access to health care, screening and everything else, we all become healthier.

The last thing I want to say is directed at the hon. Member for Stafford. Having looked at some aspects of what happened at Stafford hospital, the problem was not lack of money. Indeed, the previous Government trebled the budgets in the NHS. The problem was mismanagement. I know an inquiry is taking place at the moment. The previous Health Committee interviewed the leading players and this was a case of mismanagement. It was not about resources. I do not say that there are not resources that could not be better placed inside any NHS body, no matter what the national budgets are. I hope that the current inquiry will find that out, find the individuals who made those decisions and, if they are still working, at least retrain them. If they are in clinical positions, perhaps their regulatory boards should look at that.

I am grateful that we have had this debate. We must not stop putting it on record that we need to fund areas where there are bigger disease burdens. That is what this has been about for many years. If we look at the system for ever and a day, it is not flawed, but we will always come back to the fact that somebody thinks they are being dealt short. If we go into these communities and find out what services and provision they lack, we will find that it is increases in funds compared with other areas of England.

Emily Thornberry: The current PCT funding allocation is governed by complex rules, which are there to determine the target share of resources to which a PCT should be entitled. It is based on things like population and the local cost of health services, the level of health care needed and health inequality. That target share is known as the weighted capitation target. The formula's objective is that the recommended target share should secure equal opportunity or access to health care for people at risk, and contribute to a reduction in health inequalities. The King's Fund has said that the weighted capitation formula is world leading and

“one of the most sophisticated methods for allocating public funds anywhere in the world.”

3.15 pm

At present, as the hon. Member for Stafford said, we spend on average £1,635 per person, yet the allocation of funding to primary care trusts varies greatly. City and Hackney Teaching PCT receives the highest allocation

and Islington the second highest. The hon. Gentleman was born and brought up in Islington, so he will know that his life expectancy there would be 4.9 years less than if he had been born and brought up in mid-Essex. He has raised the example of Islington, and it is a good one. In Islington, 65.4% of people live in areas that are considered to be among the 20% most deprived in the whole of England, while the figure for mid-Essex is 4.5%. That is the difference. Islington is famous for its rich constituents, but the poorest among my constituents live much shorter lives, so given the difference in average life expectancy within Islington, imagine how poor they must be.

Unfortunately, we are talking not about equality of outcomes but about attempting to get equality of outcomes. For that reason, different amounts of resources need to go into different areas that have different challenges. Clearly, it is more expensive to provide facilities for my constituency in central London, so we need to pay our staff more and provide more for building costs and so on. We also have a large number of people who do not speak English as their first language, a much higher proportion of people with mental health problems and much greater incidence of people with drug-related problems. It is a more complex and difficult constituency and it needs more funding in order to attempt to get equality of outcomes. We are trying to tackle health inequalities, but it is hard and further work is needed. That is why I am so passionate about the issue and why different places need different resource allocation.

I have given the example of Islington because the hon. Gentleman raised it and he was born there. I have talked about my constituency—the Committee has indulged me—but I have outlined the reasons for that. I was going to make a longer speech, but given the extraordinarily powerful speech that preceded mine I do not intend to say anything further. If the amendment is put to a vote, I am confident that we will vote against it.

Grahame M. Morris: I am grateful to the hon. Member for Stafford for tabling the amendment, not least because it gives us the opportunity to have this debate. If it were passed—I understand that it is a probing amendment—it would certainly be damaging to the health of the people I represent in Easington, east Durham and County Durham. The Library's research paper indicates that the average revenue allocation per head to individual PCTs was £1,612 last year. It also notes that only 39 of the 152 PCTs received less than 95% of the English average per head spending in 2010-11, which is what the amendment seeks to do. As has already been pointed out, it is exclusively the more affluent areas that receive less, because their populations have fewer needs.

The correlation between need and funding means that an equitable service is important and that we can achieve it throughout the country. Government members of the Committee may wish to note that even the Conservative party manifesto echoed the founding principle of the NHS that health care must be free at the point of use and based upon need. The funding allocation is essential to meet that objective.

As we have heard, the amount of money allocated to each PCT is based on a complex formula—the weighted capitation formula—that determines the target share of resources for each PCT based on population, local costs of health provision, health care needs and health

inequalities. The assumption must be that the funding formula will be a matter for the commissioning board to decide, following guidance contained in the annual mandate that we discussed around earlier clauses. Unfortunately, the Minister of State, Department of Health, the right hon. Member for Chelmsford, is not in his place. If his colleague is responding, will he clarify whether the principle of a funding formula based on need will be protected in the Bill? It is not explicit; it is not spelled out. I also refer the Minister to evidence from Sir David Nicholson who told the Committee:

“The resources will be allocated to consortia on the basis of a formula that we derive around access to care.”—[*Official Report, Health and Social Care Public Bill Committee*, 8 February 2011; c. 17, Q38.]

By “we”, he meant the NHS commissioning board.

What are the accountability mechanisms and protections in place for when Sir David is no longer chief executive of the NHS commissioning board, and a new chief executive and his or her board decide to change the funding formula, as the hon. Member for Stafford suggests? The amendment raises serious questions about the future of the funding formula. We have already discussed the weakness of the provisions in the Bill to reduce health inequalities, and any possibility of a change to the funding formula would represent the greatest threat to that objective. I hope the Minister will consider some specific questions in his response. Will the Secretary of State or Parliament have any say over the formula to distribute health funding? What powers would the Secretary of State have to intervene, should such a fundamental decision be taken to change the funding formula by the NHS commissioning board?

The Chair: Order. With no disrespect to the Committee, the Minister of State, Department of Health, the right hon. Member for Chelmsford, had to leave because he has to reply to the Adjournment debate in the main Chamber—the business has collapsed and that debate is now about to start. However, he had already replied to the amendment, so it is now up to the hon. Member for Stafford to decide how he wants to proceed.

Jeremy Lefroy: I shall certainly not push this, for the reasons that some people have already brought out. I thank right hon. and hon. Members for their contributions. The reason for tabling the amendment was to have a debate about the funding formula. It is clear that it plays a crucial role in the future of NHS resources. It comes at this point in the Bill because it is the responsibility of the national commissioning board.

Points made by Opposition Members are right. There is no desire not to meet needs, as and wherever they arise. It is also recognised that those needs are greater in some parts of the country than others. I am concerned as to how flexible the formula is going to be to take into account the future needs of populations in different parts of the country. My major concern is whether the formula is sufficiently powerful and flexible to make correct allocations to populations as low as 10,000, 20,000 or 30,000, as some consortia may be of that size. As I demonstrated from the averages, as the risk pool is reduced, the variation is increased. I would like to hear convincing evidence that the formula currently used—one of the most respected around the world—is sufficiently powerful and accurate to cope with allocations to certain

consortia. It is of tremendous relevance to all Members. Whereas within their PCT they might find that the average funding formula is adequate for predicting the disease burden in their area, in a consortium in their area—even within their constituency—they might find that that formula suddenly becomes grossly inadequate.

Thinking of the South Staffordshire PCT, where my constituency is, I have seen figures suggesting that within the South Staffordshire PCT there will be great discrepancies between various consortia, naturally following on from different needs and from additional deprivation in some parts and not in others. Indeed, if consortia split a particular area—they will not in my case, but if they were to split my core town of Stafford, as could happen in some areas—there would be a tremendous difference between a consortium covering one area and a consortium covering another. This is an extremely important point that the national commissioning board needs to look at very closely. That was my particular aim when I highlighted this.

I pay tribute to the comments of the right hon. Member for Rother Valley. He hit the nail on the head on a number of points, and I hope that the Minister, although he is not in his place, will look at those points in the record as they are extremely powerful. I urge the Government to take note of the comments that have been made, and I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 20 ordered to stand part of the Bill.

Clause 21

COMMISSIONING CONSORTIA: ESTABLISHMENT ETC.

Liz Kendall: I beg to move amendment 181, in clause 1, page 25, line 38, after ‘services’, insert ‘or personal medical services’.

The clause is about the establishment of commissioning consortia. This is a probing amendment on an issue that was raised with the Opposition by the BMA. As currently worded, the clause could potentially exclude any GP practice that holds a primary medical services contract from participating in or setting up a consortia. I do not believe the Government intend to exclude these practices, which make up over 80% of all general practices in some parts of England. However, while there is a proposal in the White Paper to move towards a single GP contract, this has not yet been agreed, nor has negotiation started. The amendment seeks to ensure that all practices holding personal medical services contracts will be able to participate in the consortia. Will the Minister put it on record that that is the case?

Paul Burstow: I am grateful to the hon. Lady for the opportunity to put this on the record and, in the spirit of a probing amendment, to give her and the BMA the assurance they seek. To be clear, amendment 181 looks to make explicit, in subsection (4)(a) of proposed new section 14A, that each provider of primary medical services who is to become a member of a commissioning consortium will hold either a general medical services or personal medical services contract. The amendment is unnecessary and I shall explain why.

Clause 21 inserts Chapter A2 into Part 2 of the National Health Service Act 2006, which makes further provision about commissioning consortia. It places duties on the NHS commissioning board to ensure that, from a date specified by the Secretary of State, every provider of primary medical services in England is a member of a consortium. This is a fundamental principle of the new commissioning arrangements. Requiring all GP practices to be members of a consortium will ensure that the needs of all registered patients are represented under the new arrangements.

Proposed new section 14A(3) of the 2006 Act provides a definition. It states that a

“‘provider of primary medical services’ means a person who is a party to an arrangement mentioned in subsection (4).”

Those are people or organisations that hold, as stated in proposed new subsection (4)(a), a “general medical services contract”; those who have a primary medical services contract that, as described in proposed new subsection (4)(b), comes under

“arrangements under section 83(2) for the provision of primary medical services of a prescribed description”;

and those who have an alternative primary medical services contract that, as described in proposed new subsection (4)(c), comes under

“section 92 arrangements for the provision of services of primary medical services of a prescribed description”.

3.30 pm

Where two or more individuals practise as GPs in a partnership, it is the partnership that is treated as a single provider of primary medical services, not the individuals in that partnership. Similarly, where two or more individuals are parties to an arrangement in proposed new subsection (4) but are not in a partnership, they would be treated as one person for such purposes. The new arrangements will therefore adequately satisfy the concerns about which the hon. Lady and the British Medical Association have sought reassurances. I therefore hope that she will withdraw the amendment.

Liz Kendall: I am grateful to the Minister for that clarification. More importantly, GPs on primary medical services contracts will also be grateful for it. On that basis, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 182, in clause 21, page 27, line 35, leave out ‘Regulations may make provision’ and insert

‘The Board must, after consultation, determine and publish criteria.’.

The Chair: With this it will be convenient to discuss amendment 183, in clause 21, page 28, line 20, at end insert—

‘(6) In all cases the consortium must consent to the variation.’.

Liz Kendall: The amendments relate to the degree to which the NHS commissioning board may exert power over commissioning consortia under the clause, which is about how consortia will be established. They arise from a concern that the board may have too much power over consortia. Important issues have been raised by several organisations and they need to be clarified.

[Liz Kendall]

One proposed new section in the clause currently provides that regulations may be issued about the circumstances in which the NHS commissioning board may grant or refuse applications to become a commissioning consortium, and about the factors which it needs to take into account in doing so. Another states:

“Regulations may...confer powers on the Board to vary the constitution of a commissioning consortium”.

In other words, the Secretary of State may—without any further consultation with Parliament, GPs, clinicians or others—issue regulations that will allow the board to determine which people may form a consortium and specify details of the constitution that will guide its work.

Amendment 182 would require the board to publish and consult on the criteria used to determine whether applications to become a consortium are refused. If the board says, “Sorry, your group of GPs can’t be a consortium,” it will have to set out some criterion by which it has made that decision; it cannot do that arbitrarily.

Amendment 183 would make it clear that the board may vary the constitution of a consortium only if that consortium agreed. As later amendments are drafted to show, having constitutions as the only attempted kind of governance structure for consortia is inadequate. At this stage, where we have only such constitutions, it is important that the board may vary them only with the agreement of the consortium concerned.

Opposition Members and, I hope, Government Members, will agree that, on the two key issues of who can form a consortium and what constitution guides its work, the views of GPs should be heard and, on the constitution, they should certainly agree that themselves.

Paul Burstow: The amendments relate to the variation of consortia constitutions. The hon. Lady is absolutely right. We want to make sure that GPs are in the driving seat and shape the constitutions that provide the governance arrangements for those consortia. The clause is framed to ensure the degree of flexibility and freedom that is important to driving better, clinically-led commissioning in the future.

The regulation-making power in proposed new section 14E(3) provides for regulations to determine the circumstances in which the NHS commissioning board must or may grant, or must or may refuse a change to a constitution of a consortium—the factors the board must or may take into account and the procedure for making and determining such decisions.

Amendment 182 would change that duty, as the hon. Lady has described, for the board to consult on those criteria before determining and publishing them. We are a puzzled about the purpose of the amendment, given that a number of previously tabled amendments have quite rightly seen parliamentary scrutiny as the gold standard. If regulations were laid, they would be subject to that gold standard of parliamentary scrutiny and debate. It therefore seems strange that on this occasion the amendment seeks to move away from an opportunity for hon. Members from all parts of the House to debate, examine and question the intentions of Ministers.

The Bill sets out, in a number of places, the need to make further, more detailed, provision in secondary legislation regarding certain matters, including the process for establishment of consortia. It is intended that the interactions between consortia and the board will be conducted in a transparent, rules-based manner where consortia are aware of the expectations on them and the board has appropriately circumscribed powers. The prescription of further detail in regulations is considered necessary to achieve that, but will ensure that there is a clear, rules-based framework within which we envisage that consortia would act. We will ensure that regulations are laid before Parliament on those criteria to provide the appropriate opportunity for hon. Members and others outside the House, including those with the closest of interests, to scrutinise and comment on those proposals.

Amendment 183 would require consortia to consent to the variation of their constitution, if that was considered necessary by the NHS commissioning board. As we can see in proposed new section 14F, the board already has the duty to consult the relevant consortium or consortia when varying a consortium’s constitution and must, where possible, seek agreement. That is, therefore, already provided for in the Bill. However, in proposed new section 14A, the board also has a duty to ensure a comprehensive system of commissioning consortia across the country. In order to fulfil that duty, the board might need to make changes to the membership, or to the area of a consortium—for instance, where a GP practice ceases to operate and arrangements are made for a new GP practice to take over responsibility for those particular patients.

In those circumstances, it might be necessary for the board to make such arrangements without the consortium’s agreement. A possible unintended consequence of the amendment’s intention to make the board seek consortia’s agreement on all constitutional changes is that it could lead to a gap in consortia coverage to the detriment of patient care. For those reasons, we have to resist the amendments. I hope that they are probing amendments and that I have reassured the hon. Lady. It would still be for the board to decide who becomes a consortium. We have allowed for regulations to set out the circumstances and procedure for doing so and the regulations just provide for the framework of those decisions. Those decisions, and the framework governing them, should be subject to regulation, and therefore parliamentary scrutiny.

Liz Kendall: I thank the Minister for his answer. I still believe that the Bill leaves in doubt whether the national board will be able, more arbitrarily, to agree or not to a consortium’s being established, and then to vary its constitution by saying who should or should not be a member. I take into account his point about a general practice suddenly collapsing. One would hope, however, that that would not happen suddenly, because there would be early insight. If that were not the case, the system that he proposes would not be working.

Paul Burstow: One purpose of drafting legislation is to ensure that all eventualities are covered, which the provision aims to do.

Liz Kendall: Some GPs are already concerned about the changes in the Bill. They are concerned that the board has powers over how they choose whether a

consortium exists. It has powers over whether they can vary the membership, or the area, without the consortium's agreement and without properly setting out the criteria by which they would be judged. Opposition Members share such concerns, so I press the amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 11.

Division No. 23]

AYES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

NOES

Brine, Mr Steve	Lefroy, Jeremy
Burstow, Paul	Morgan, Nicky
Byles, Dan	Poulter, Dr Daniel
Crabb, Stephen	Pugh, John
de Bois, Nick	Soubry, Anna
James, Margot	

Question accordingly negated.

Liz Kendall: I beg to move amendment 185, in clause 21, page 28, line 41, leave out 'regulations may make provision' and insert

'The Board must, after consultation, determine and publish criteria.'

The amendment is similar to the previous two. The Bill provides that regulations can be issued to determine the circumstances within which the board can dissolve a consortium and the factors that it must take into account in doing so. The British Medical Association and other organisations are worried that such a power could give the board—in reality, the Secretary of State—complete control over whether a consortium is dissolved. The amendment proposes that the board publish the criteria that it will use to make such a fundamental decision in future. I hope that hon. Members on both sides will agree that the power arbitrarily to dissolve a consortium is not one that we want to see. I urge them, therefore, to accept the amendment.

3.45 pm

Paul Burstow: If the hon. Lady's assertion is that the clause is an attempt to create a power to arbitrarily dissolve consortia, I too would urge members of the Committee to support her amendment. However, that is not the purpose of the clause, so her amendment is unnecessary. Her amendment would change the relationship between the Secretary of State and the board and remove Parliament's ability to scrutinise the criteria that would be used to determine applications for dissolution.

As we discussed in relation to amendments 182 and 183, our policy intention is clear: interactions between consortia and the board should be conducted in a transparent and rules-based manner, with consortia being aware of the expectations on them and the board having appropriately circumscribed powers. We believe that the prescription of further detail in secondary legislation is necessary to achieve that; to allow the board to set its own criteria, even after consultation, would go against that direction of travel.

The hon. Lady may not believe this, but we have every confidence that Parliament is able to be the representative body to scrutinise and feed in the views of the public, patients and GPs at the time of deliberation of such regulations. On that basis, I urge colleagues to oppose her amendment, unless I have persuaded her to withdraw it.

Liz Kendall: I am grateful for the Minister's reply. The Government say that they believe in "no decision about me without me". Although Opposition Members will of course feed in their views about what GPs think about any regulations that allow the board to dissolve a consortium, I am sure that GPs—particularly those in the consortium involved, who may want to express that view directly by themselves—will not be convinced by the Minister's answer. I should like to press the amendment to a vote.

The Committee divided: Ayes 9, Noes 11.

Division No. 24]

AYES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

NOES

Brine, Mr Steve	Lefroy, Jeremy
Burstow, Paul	Morgan, Nicky
Byles, Dan	Poulter, Dr Daniel
Crabb, Stephen	Pugh, John
de Bois, Nick	Soubry, Anna
James, Margot	

Question accordingly negated.

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

Mr Barron: The clause states that each consortium must have an accounting officer. I have looked through the explanatory notes, which go into great detail about what the accounting officer will do, including their accounting and auditing functions. They also state:

"The accountable office is also responsible for ensuring that the consortium fulfils its duties to exercise its functions effectively, efficiently and economically under new section 14K, and...under new section 14L in relation to improvement in the quality of services. The accountable officer must also ensure that the consortia exercises its functions in a way which provides good value for money."

If one went through the rest of them—I do not intend to do so—one would see that they then talk about the Comptroller and Auditor General and everything else. They do not mention whether there is any accountability to health and well-being boards or anybody in the localities. Will the Minister say that that will be covered because of everybody else's powers? Is there any link between the local boards and the accountable officer inside a consortium?

Paul Burstow: The right hon. Gentleman has rightly guessed that I will refer to later clauses that address those issues about the relationship between the health

[Paul Burstow]

and well-being board and the consortium. Those are largely addressed through the existence of clauses dealing with joint strategic needs assessments, the production of joint health and well-being strategies and the fact that both commissioners within the local authority and the consortium will have to have regard to them.

That is the nature of the relationship; it is not a relationship in the way that the right hon. Gentleman is trying to suggest. I hope that that answers his question—I am sure that we will return to it in some detail when we come to the relevant clauses—and that, therefore, the clause will stand part of the Bill.

Liz Kendall: This is a clause stand part debate, so I will discuss the wider issues and concerns about commissioning consortia at a later stage. In discussing the amendments to schedule 2, I will mention particular worries about governance and accountability, which follow on from the points made by my right hon. Friend the Member for Rother Valley.

We are not discussing it with the amendments to schedule 2, so I particularly want to highlight and ask the Minister about paragraph 3(3) of new schedule 1A to the 2006 Act, inserted by schedule 2 to the Bill, which says, when looking at the constitution of a consortium, that the constitution

“may include provision for any functions of the commissioning consortium to be exercised on its behalf”

by any of its committees or sub-committees. The constitution can, therefore, say that anything that the consortium does could be done by a separate committee or sub-committee and that those committees can consist of not only people who are members of the consortium, but people who are not employed by the consortium. That means that a consortium could delegate its entire commissioning function—[*Interruption.*] I hope that Government Members are listening—[*Interruption.*] Am I out of order? I am sorry.

The Chair: Order. Yes, you are. You are dealing with the schedule, but we are still dealing with the clause stand part. You are making a speech relating to schedule 2.

Liz Kendall: The difficulty is that my point is about schedule 1, which is not on the selection list under schedule 2.

The Chair: I am afraid that we have passed schedule 1.

Liz Kendall: For clause 21?

The Chair: This is schedule 2 on this clause.

Liz Kendall: I am sorry if I have got this wrong. I thought we were having a clause stand part debate on clause 21.

The Chair: Yes, we are.

Liz Kendall: If I wanted to make a point about schedule 1, I thought that I should do that under the amendments to schedule 2.

The Chair: No. You should restrict your comments to the items in clause 21.

Liz Kendall: I am terribly sorry, Mr Hancock. I did not understand that, so I will make my point later.

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

The Committee divided: Ayes 11, Noes 9.

Division No. 25]

AYES

Brine, Mr Steve	Lefroy, Jeremy
Burstow, Paul	Morgan, Nicky
Byles, Dan	Poulter, Dr Daniel
Crabb, Stephen	Pugh, John
de Bois, Nick	Soubry, Anna
James, Margot	

NOES

Abrahams, Debbie	Smith, Owen
Barron, rh Mr Kevin	Thornberry, Emily
Blenkinsop, Tom	Turner, Karl
Kendall, Liz	Wilson, Phil
Morris, Grahame M. (<i>Easington</i>)	

Question accordingly agreed to.

Clause 21 ordered to stand part of the Bill.

Schedule 2

COMMISSIONING CONSORTIA

Liz Kendall: I beg to move amendment 174, in schedule 2, page 227, line 11, at end insert—

2A (1) The consortium must have a board that includes—

- (a) a chair appointed by the membership of the consortium;
- (b) the accountable officer if this is not the chair;
- (c) at least three non-executive directors appointed by the chair that are not members of a commissioning consortium;
- (d) at least one patient representative appointed by the local Healthwatch organisation;
- (e) such additional clinical specialists that are needed to ensure that expert advice is available within the Board for the commissioning of services, including—
 - (i) a registered nurse, and
 - (ii) a member of the allied health professions;
- (f) at least one representative from local authorities in the consortium area;
- (g) no more than four other members of the consortium.

(2) The consortium must meet in public.

(3) The agenda and minutes from the consortium board and any sub-committees must be published.’

The Chair: With this it will be convenient to discuss the following: Amendment 175, in schedule 2, page 228, line 28, leave out ‘Board’ and insert ‘commissioning consortium board’.

Amendment 176, in schedule 2, page 228, line 29, leave out ‘Board’ and insert ‘commissioning consortium board’.

Liz Kendall: Amendment 174 and related amendments 175 and 176 go to the heart of Opposition Members' concerns about the complete absence of a proper governance structure for commissioning consortia. Our concerns are shared by many people in the NHS.

If consortia are to be responsible for £80 billion of taxpayers' money and are likely to shape much of the NHS in future, it is astonishing that there should be no requirement for the consortia to have a board. There is no requirement for a chair or any non-executive directors. If there is no board, there is no requirement for any clinician to be on the board, because the board is non-existent. There is not even a requirement for a GP, let alone hospital or other doctors and registered nurses, or professions allied to medicine. There is no requirement for a patient representative or member of a local authority to be on the board, which of course does not exist. There is no requirement for the consortia to meet in public or to publish their agendas or any of their minutes.

I want to raise the point that I erroneously tried to make earlier, which is about the powers that a consortium has. Under its constitution, it can delegate any of its functions to a committee or sub-committee, and the people on those committees need not be a member of the consortium, nor even employed by it. Does the Minister agree that that raises the possibility that consortia can delegate their entire commissioning functions to individuals or organisations outside the NHS, including the private or voluntary sector, without any recourse to patients or the public, and with no requirement to publish any information or to meet in public? That is a very real concern. Under the Bill, that is exactly what consortia will be allowed to do.

The Government claim that they want to devolve power. I hate to use a cliché, but I will: with power comes responsibility. But there is nothing in the Bill to indicate that consortia will have effective governance structures. I know that some Opposition Members have run their own businesses. I have been a director of a charity. We know that it is vital to have effective governance structures and non-executive directors to challenge executive directors.

The previous Government set up foundation trusts. There was a controversial debate about them, and one of the big issues raised was that they should have a board. Who should be on the board? How should they be strengthened? How can people in the system be challenged? I find it astonishing that the consortia will have no such board. That is very worrying, as they are going to be responsible for £80 billion of taxpayers' money. Who will provide the challenge and scrutiny? They do not have to meet in public, as do the boards of primary care trusts. They do not have to publish their agendas or minutes of board meetings, because no board exists.

This is one of the most fundamental concerns about consortia. If they are going to exist, they need to be run effectively and properly. We would never put £80 billion into people's hands without a board in any other walk of life.

4 pm

Before I become even more passionate about the point, I should say that amendments 175 and 176 state that there is a board, which amendment 174 attempts to

establish. That board should be able to appoint its accounting officer, which is how other organisations, businesses and charities normally work. At the moment, the national NHS commissioning board appoints the accounting officer of consortia, which is a very top-down approach.

In any business or charity—or, indeed, in an FT—the board and the non-executives appoint those positions. That goes to the heart of the Bill and I wish that we had longer to debate it, because I think that it is important. I hope that hon. Members on both sides of the Committee will support the amendments.

John Pugh: The hon. Member for Leicester West is right in saying that the issue goes to the heart of the Bill, because it centres on what I regard as a fundamental flaw. The amendment deals with a number of things: transparency, freedom of information, how far delegation goes and the composition of the board itself. I will park the other matters, which are major in themselves, and talk only about the composition, because that most impacts on me as an issue.

I am not against the idea of commissioning consortia. I am not against the idea of clinically led, non-top-heavy consortia controlling most of NHS expenditure; I think that that is how it should be done. I would prefer such consortia to be coterminous with local authorities for all sorts of reasons, which I will not go into now, but I have not accepted the argument that commissioning consortia should consist solely of GPs. The amendment adds a range of people who might be involved, including registered nurses and members of allied health professions.

I do not want to get into exactly what the composition should be—I am not certain what it should be—but I am fairly certain that there are inherent dangers in making the composition solely GPs. I have three reasons for saying that. First, GPs, within their remit, cannot possibly commission all local services. That is why dentists were excluded, and we ended up in the rather bizarre situation of having local dentistry commissioned from a central location such as Yorkshire or London, which is certainly not the appropriate place for local dentistry to be commissioned from.

Secondly, there is a question over GPs' remit in how they performance-manage themselves. A report a few days ago showed that GPs were falling down badly in early diagnosis of cancer, which is a genuine concern. I know a young man who died having been to his GP several times feeling rather languid and tired; he was diagnosed inappropriately, not referred to a blood test early enough and eventually died because his leukaemia had developed too far before it was diagnosed.

Such things can happen in all health systems, and Ministers present a good argument from time to time that if there is good peer review among GPs, performance improves. Peer review certainly does that. One can have peer review, and it can be very good, but one can also have peer collusion, and there has been a history of that in the NHS.

Grahame M. Morris: I agree with the excellent points that the hon. Gentleman makes. Would he care to comment on the question of conflict of interest, which was raised yesterday, in which a consortium made up exclusively of GPs could place contracts with private

[Grahame M. Morris]

health care companies—primary health care providers—of which they were part owners? Should that be addressed in the Bill?

John Pugh: Astonishingly, I was just about to make that point. There must be telepathic communication between me and the hon. Gentleman. I want to put the point mildly, but there is a genuine risk of self-interest in commissioning practices. If they do not believe that GPs can be self-interested, I recommend that all hon. Members get a copy of the National Audit Office report on the GP contract, which we, on this side, all agree was horribly botched and led to a horrid overspend.

Practices were rewarded. GPs were rewarded for a range of sometimes superfluous but often very helpful activity, and then the spoils were divided up. Looking at the analysis of what happened, we find that as the money went into practices, nurses, salaried doctors and all sorts of people like that did blood pressure tests. I think 80% of the reward to the practice went to the partner in that practice. That tells us something about human nature. I do not suppose anybody else running a business would have done a great deal differently, but it shows that GPs are no more innate altruists than any of us.

GPs are good, decent people doing an important job, but if they have an opportunity to improve their situation financially, they will take it, and that could apply to quite simple things. I am not talking about dreadful issues of conniving with private companies and such things, but something such as monitoring blood pressure. It is a crucial thing that happens all the time across the country and has enormously beneficial effects if done properly. Pharmacists can do it in a convenient and helpful way, and they add a great deal to the performance of the NHS in their areas. However, if a pharmacist does it, and it is not done in a GP's surgery by a GP, under the current terms of the GP contract that is a loss of income. Is there not an innate temptation for GPs not to commission so much pharmacy activity, if that is what ends up happening? I am not saying that they necessarily would do that—one would hope that they would not—but they could, and that concerns me.

The risk of self-interest genuinely leads me to believe that somebody needs to be there to ensure that that self-interest is less emphatic and indulged. There are various reports of this, but if anybody read *The Times* yesterday, they will have seen accounts from Dr Gerada and others of surveys showing that where GPs were given the opportunity, most behaved perfectly honourably, but some behaved more acquisitively, if I may put it like that.

The self-interest argument and the fact that the GPs' remit is limited strike me as unassailable arguments for having more than GPs. I cannot think what the answer is to that. Nobody will stand here and argue that GPs will be at less of a risk of self-interest if they are running the show themselves or that GPs, because they are GPs, are better at commissioning dentistry and other services. The arguments are irrefutable.

The third argument, which occurred to me only while listening to our deliberations today, is that we have just discussed what would happen if GP practices folded.

What would happen is that the consortium would ultimately fold and fall apart. Making the local NHS depend on such contingent events is not a stable model. After all, in the system we have, if GP practices come and go, in and out of the PCT or whatever, there is still a commissioned and funded service.

One might go through a period in which the GP consortium was in a state of upheaval because the doctors fell out among themselves. That happened to me. The surgery I attended was broken up due to two difficult doctors who could not get on with one another. We need only three or four of those incidents across the piece and we end up with an unstable consortium. Why build the NHS on potentially unstable units? I am in favour of clinically led commissioning consortia and of not having bureaucracy. However, there are three very satisfactory reasons why, if we are going to have them, the case for making commissioning consortia just GPs, with as little transparency as we have here and with maximum possibilities for delegation left, right and centre, is a very feeble case indeed.

Nick de Bois: I wish to register couple of points briefly. We should carefully consider ensuring that the consortia established are represented at a senior level with, at the very least, GP engagement at the very top of the consortium. That is important, and as I understand it, the Bill allows for it. I would always be concerned about a consortium that did not reflect it. At the end of the day, I would be concerned if we ended up with a pure management function without the GP input. I therefore think that that needs some examination, and I hope that we can find some comfort for that later.

I take the point made by the hon. Member for Leicester West about governance and financial responsibility. My examination of the Bill suggests that there will be considerable governance from the national board level down to the consortia. While I respect the fact that quite a lot of money will be handled here, there seem to be a sufficient number of steps in place to identify and, if necessary, change things if there are financial problems. Again, I am quite happy to look into that in more detail as we go along. My principal concern is still about GP representation.

Jeremy Lefroy: I associate myself with the comments made by my hon. Friend the Member for Enfield North, and with most of those made by my hon. Friend the Member for Southport.

This part of the Bill, which relates to the governance of consortia, is the one with which I have the most concern. I do not think that the amendment gets it right, but neither do I think that the Bill does so. I do not like talking about a third way, but I would ask the Government to look closely at how the Bill's position may be improved. As it stands, schedule 2 is very bare. The constitution will simply need to specify the members, the name and the area of the consortium and various other details.

It is essential that every consortium has input, not just advice, from local clinicians, nurses, hospital clinicians and clinicians who work in the community. It is advisable for that to be either written in the Bill or included in the criteria that the national commissioning board would have to look at before approving a particular consortium. The reasons that I would give for that have been outlined by my hon. Friend the Member for Enfield North.

In my experience, GP practices are extremely varied. Most of them are excellent, and most of the rest are very good, but some of them can be somewhat lacking—*[Interruption.]* The hon. Member for Islington South and Finsbury has gone much further than I would. I believe that that is a serious point. I do not want to lengthen my remarks, and I think the Minister has got the gist of what I am saying. I do not think the amendment does the job. It is too specific and precise, and would probably result in an unwieldy board. On the other hand, the Bill needs to state clearly that consortia need to have more input at the board level from those in the wider local health community.

Mr Barron: I support the general feel of the amendment, and I agree with the hon. Member for Southport. There are at least a couple of areas in my constituency where GP practices have completely fallen in. We tend to forget that they are local businesses. Quite often, there are four or five GPs, two of whom will be the strong partners and be an influence on the rest. I had a situation where one completely broke. Another surgery was built nearby, costing I think over £800,000, and it facilitated dealing with the problem. It was not necessarily built there because there was a need, but because there was a problem with the GP practice.

My other example I mentioned in an earlier debate: the walk-in centre in Rotherham. When that was being argued for, paid for and built, in 2006 one of my GPs, out of a practice of four, was handing out letters telling people not to vote Labour at the next local government elections. I discussed it with him publicly in the end, and with the local medical committee, who then thought it was a good idea. However, in my view, he was trying to protect his capitation fees and look after his financial interests.

As has been pointed out by numerous Members, we must be aware that GPs are human, like us, and they look after their interests. I had some misgivings when the concept of GP commissioning came up. I had deep discussions with GPs and others, not just in my constituency, but in the wider area. There are some progressive GPs in my constituency, with youth and occupational health clinics and things like that. I am pleased to say that they are more likely than others to be leading commissioning, but others are backwoodsmen and women who see nothing much beyond the surgery door and the patients and their prescriptions. The Committee might think

that that analysis is hard, but it is the case. Handing power to such GPs, as suggested, without more checks and balances, is wrong. I genuinely think it is wrong.

I spent nine years as a lay member of the General Medical Council. For a number of those years, I was a member of fitness-to-practice committees, dealing with GPs. There poor, struggling, single-handed GPs in inner-city areas, where workloads were far too high and everything else, but beyond those, practices often fell down or the patients were failed because of arguments within the businesses. I have seen careers ruined. One man was referred to in the *Yorkshire Post* as Shipman No. 2. That man is probably still suing now—the medical director who accepted that from his partner. A few weeks later, I found out that it was said that he had been doing what Harold Shipman had been doing. That was accepted, and it ruined a career. We have to be very careful, because people in such situations get motivated for different reasons.

The amendment is probably too prescriptive about who should or should not be on the board—I accept that. I hope that my hon. Friends do not press the amendment to a Division, but Ministers need to put something more in the Bill.

Some non-executive members of my PCT deal with cases where one of my constituents has been denied funding by the PCT and I have said “Appeal under exceptional circumstances.” Non-executives often chair such hearings. I have won some and lost some. I felt strongly about the issues, but having such influences on the board is no bad thing. I accept we have got HealthWatch, and what is beyond that as well, but having such people on the board is no bad thing.

I will finish with something I have always felt to be a tension. We went through the clause earlier this afternoon. Two GPs can, effectively, start a consortium, but others have to join. That will be no easy passage—some do not like each other in the same practice, never mind a practice in a neighbouring village. Leaving the lead to GPs and to GPs alone is probably not sensible. Perhaps someone else ought to be on the board, on occasion, bringing people together for the general good.

Ordered, That the debate be now adjourned.—(*Stephen Crabb.*)

4.19 pm

Adjourned till Tuesday 8 March at half-past Ten o'clock.

