HEALTH AND SOCIAL CARE BILL

Thirteenth Sitting
Tuesday 8 March 2011
(Morning)

CONTENTS
Written evidence reported to the House.
Schedule 2 agreed to, with an amendment.
Clause 22 under consideration when the Committee adjourned till this
day at Four o’clock.
Members who wish to have copies of the Official Report of
Proceedings in General Committees sent to them are requested to
give notice to that effect at the Vote Office.

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

not later than

Saturday 12 March 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY
FACILITATE THE PROMPT PUBLICATION OF
THE BOUND VOLUMES OF PROCEEDINGS
IN GENERAL COMMITTEES
The Committee consisted of the following Members:

*Chairs:†Mr Jim Hood, Mr Mike Hancock

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Tuesday 8 March 2011
(Morning)

[MR JIM HOOD in the Chair]

Written evidence to be reported to the House

HS 74 Tina Read
HS 75 L A Gilbert
HS 76 Jane Schofield
HS 77 Susan Ackroyd and Tess Harris
HS 78 Janet Porthouse
HS 79 David Feather
HS 80 United Kingdom Council for Psychotherapy
HS 81 Foundation Trust Governors’ Association
HS 82 Weight Watchers UK Limited
HS 83 Men’s Health Forum
HS 84 Lisa Smeaton
HS 85 Roy Castle Lung Cancer Foundation
HS 86 British Heart Foundation

10.30 am

Derek Twigg (Halton) (Lab): On a point of order, Mr Hood. I seek clarification. At the start of the Committee, you said that, as a general rule, you and your colleague Chair, Mr Hancock, did not intend to call starred amendments unless they had been tabled with adequate notice. We notice that in the past 24 hours the Government have tabled well over 100 amendments that, obviously, we have not yet had time to look at properly. We need to get to clause 50 today, so we will not have much of a chance to discuss many of the amendments, in particular those to the schedules.

May I clarify, Mr Hood, whether it is your intention not to call those amendments, given that they were not ready in time for the Committee? The situation appears to be another example of a Government in disarray; only last week, they submitted amendments in respect of their U-turn on prices. We are concerned about the situation and we seek your advice, Mr Hood.

The Chair: I will deal with the point of order as quickly as I can, so that we can move on.

I am aware that a large number of Government amendments were tabled yesterday. As the hon. Gentleman rightly said, my fellow Chair and I said at the start of the Committee that, as a general rule, we did not intend to call starred amendments that had not been tabled with adequate notice. As right hon. and hon. Members can see from the official selection on the groupings list, the amendments have not been selected for today’s sittings.

So that we can get on with our business today and get through as many clauses as right hon. and hon. Members wish, I suggest that I have a conversation with the Government and those on the Opposition Benches, probably after we suspend for lunch. We can have a discussion on how to resolve the issue by the time we come back in the afternoon.

As we know, the Chair will not consider starred amendments, in particular from Ministers. We will seek to resolve the matter by discussion with Front Benchers from both sides.

Schedule 2

COMMISSIONING CONSORTIA

Amendment proposed (3 March): 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.’.—[Liz Kendall.]
Amendment 174 seeks to introduce a requirement for the consortium to have a board with rigid membership requirements. That membership must include particular clinical specialists, at least one representative from the local healthwatch organisation, and at least one from local authorities in the consortium area. It would also limit such boards to having no more than four other members of the consortium, irrespective of the number of practices within it.

Clause 21 introduces schedule 2, which makes further provision on commissioning consortia, including provisions about consortia constitutions, into which the amendment would be inserted. I make clear to the Committee that the constitution must specify clearly in its activities the arrangements that the consortium has put in place to discharge all its duties and functions. Unlike the present arrangements for primary care trusts, the constitution will set out clearly the governance and decision-making arrangements, and it will be a publicly available document.

When authorising consortia, the national health service commissioning board is required to check that the arrangements put forward by a consortium in its constitution are appropriate. The agreed and published constitution is fixed on establishment, and the commissioning board can exercise its intervention powers should a consortium not act in accordance with it. The check and balance in the system ensures that at all times consortia will have governance arrangements of their own design, but that those will be independently assessed and approved by the NHS commissioning board. A lack of prescription in the Bill does not equate to a lack of governance, as has been suggested by some hon. Members.

The hon. Member for Leicester West has overlooked the purpose of the new legislative framework that the Bill proposes, which is simply to liberate rather than to micro-manage the NHS. General practices will have the flexibility to form consortia to operate in ways that they consider will secure the best health care and health outcomes for the patients and communities whom they serve.

The hon. Lady picked up on the point that consortia may appoint committees or sub-committees, and that any such committees should consist of or include persons other than consortium members or employees. The intention of that measure is to allow for the membership of lay people or other health care professionals. I assure her that she is mistaken in thinking that the actions of sub-committees or committees will not be bound by the duties placed on the consortium—they are bound by such duties.

Liz Kendall (Leicester West) (Lab): Can the Minister confirm that sub-committees and committees of the consortia will not include members from private companies, who might be allowed to take over functions such as the commissioning role of the GP consortia? Can he give me a categorical assurance?

Paul Burstow: I am grateful to the hon. Lady, because she has guessed what I was about to come to in my remarks. Let us be clear: when a consortium delegates a function to a sub-committee or engages an external organisation—perhaps of the sort that she had in mind during her question—it remains responsible and accountable for the discharge of that function; it cannot sub-contract its responsibility under the Bill. The consortium must ensure that when a function is carried out by another organisation on its behalf, the approach taken complies with the duties placed on it by the Bill. The NHS commissioning board will hold consortia to account for the appropriate discharge of their functions.

Graeme M. Morris (Easington) (Lab): It would be helpful if the Minister gave some further clarification. I tabled a parliamentary question to the Minister, the right hon. Member for Chelmsford. It followed an answer that he gave on 14 February about general practitioners and whether a licensed private health care provider would be permitted under the legislation, first, to provide services, and secondly, to enter into a contract with GP consortia to carry out duties in relation to its work as a commissioning body. His response was:

“Consortia will be free, within the legislative framework, to make the decisions that they judge are right for patients and provide value for money. This includes commissioning services from the public, voluntary or private sector.

General practitioner consortia will receive a maximum management allowance to reflect the costs associated with commissioning.”—[Official Report, 2 March 2011; Vol. 524, c. 495W.]

The Chair: Order. The hon. Gentleman’s interventions must be a bit shorter than that.

Paul Burstow: The hon. Gentleman has read out part of the answer that my right hon. Friend has given him. As he points out, we intend that a commissioning consortium should be able to commission support from an outside provider—a charity, for example, such as the Neurological Alliance—to ensure that access is available to appropriate clinical and patient expertise regarding commissioning activity. That is something that Members on both sides of the Committee have sought to probe and test. There is nothing sinister involved; it is exactly what hon. Members on both sides have sought to achieve, and the Bill will enable it.

Under new section 14O of the National Health Service Act 2006, as detailed in clause 22, the Bill provides that consortia will be under a duty to seek appropriate advice from health experts when they are carrying out their functions. I suspect that the hon. Member for Easington was alluding to that point in his intervention.

In drafting the Bill, we have avoided the temptation to micro-manage. We have not constrained the ability of consortia to seek advice and input from those health professionals who are best placed to give it. By naming particular professional groups in the Bill, we would impose an unhelpful restriction on the ability of consortia to access appropriate clinical advice, which is their duty.

My hon. Friend the Member for Southport has raised some important concerns about the emphasis on GPs, and he has expressed a particular concern about the ability of GPs properly to commission services without access to specialist knowledge. The new model for commissioning is based on the system of registered lists of patients held by GP practices. GPs play a crucial role, as I am sure hon. Members on both sides of the Committee acknowledge, in co-ordinating patient care and committing NHS resources through their daily clinical decisions in primary care. We believe, therefore, that the emphasis on GPs as the foundations for consortia is right.

My hon. Friend makes an important point, however, about the essential contribution of other clinicians. Consortia will find it impossible to secure improving
health outcomes without the right advice. Effective commissioning will require the full range of clinical and professional engagement alongside that of local people. Hospital doctors, nurses, allied health professionals and others all have a vital role to play in developing services and improving health outcomes. How a consortium goes about that is rightly a matter for it, and it will be held to account for the outcomes that it achieves. The consortium will set out its approach to discharging its duties in its constitution, which will be scrutinised and approved by the NHS commissioning board at the point of establishment.

My hon. Friend the Member for Stafford considered that that was an essential area that should be included in the criteria that the commissioning board would use to assess consortium establishment applications. New section 14C of the National Health Service Act 2006, as set out in clause 21, contains a regulation-making power that will allow provision to be made regarding the factors that the board must take into account in deciding whether it is satisfied that a consortium has made appropriate arrangements to discharge its functions.

My hon. Friend the Member for Southport also raised concerns, echoed by the right hon. Member for Rother Valley, about GPs acting in a self-interested way when commissioning services, and about the potential instability that might be caused to a consortium if a practice were to fail. That issue is clearly important, and it needs to be aired and properly scrutinised in Committee. The Committee will have the full opportunity to discuss conflicts of interest when it considers amendments 211 and 217 to clause 22. Those are valid points, and we have made provision for them in the Bill.

10.45 am

I will briefly describe what we have done. Without wanting to pre-empt the debate, I should say that consortia must set out in their constitutions the arrangements for making commissioning decisions and managing conflicts of interest. The board will review the constitution and the appropriateness of such arrangements at the point of establishment of a consortium. Clause 63 allows regulations to impose requirements on consortia with regard to good procurement practice and, importantly, the management of conflicts of interest.

I can also reassure the Committee that the failure of individual GP practices will not lead to the failure of a consortium; quite simply, they are two separate legal entities. However, the way in which primary care is delivered contributes to the achievement of consortia objectives in improving health outcomes. It is for that reason that consortia have a duty under new section 14M to support and assist the board in its duty to improve the quality of primary care delivered by their member practices, which we have already considered in this Committee. In the event that the practice loses its primary care contract, the commissioning board has the power under new sections 14Z3 and 14Z4 to assess the impact on commissioning arrangements. The board can then offer assistance and support to the consortium under the powers under new section 14X of the Bill or exercise its intervention powers to ensure that there is no risk whatever to patients. I hope that that provides the assurance that hon. Members sought in last Thursday’s debate.

I turn to the points raised about public involvement and engagement. New section 14P in clause 22 places a duty on consortia to ensure that people who receive a service are involved in both its planning and development. As with the duty to seek appropriate clinical advice, consortia will have a flexible approach to how they exercise that duty and engage with communities in the ways that make sense locally. That is to ensure the flexibility and freedom specified in new section 14Z: consortia are obliged to hold a public meeting at which their annual report will be presented to members of the public. Consortia may go beyond that minimum level of prescription, and the board will have the power to issue guidance to consortia on the discharge of their public involvement duties to which the consortia must have regard.

Consortia will need to develop effective ways of harnessing the patient and public voice, so that commissioning decisions are increasingly shaped by people’s experiences and aspirations as to what high-quality health services mean to them and whether their express needs are met. I suspect that that is something that all members of this Committee want to see, and it is provided for by this Bill.

Amendment 175 would specify that the accountable officer is to be appointed by the commissioning consortium board. Amendment 176, moved last Thursday, would specify that the board may appoint a person to be an accountable officer for more than one consortium. It is the concern of the hon. Member for Leicester West that the consortium will have no say in the selection of its accountable officer. I can reassure both her and other hon. Members. Although the Bill does provide for the NHS commissioning board to appoint a consortium’s accountable officer, it will be a matter for the consortium to choose who is put forward. Subsection (3) of new section 14B states that an application to become a commissioning consortium must be accompanied by the name of the person whom the consortium wishes the NHS commissioning board to appoint as its accountable officer.

The role of the board in confirming the appointment is to put a check or balance on the suitability of the proposed accountable officer. That is an important check in the system; in some ways, it is strange that Opposition Members have sought to remove it from the Bill. Schedule 2 also provides in paragraph 9(3) that the NHS commissioning board may appoint a person to be an accountable officer for more than one consortium. Again, it would be for the consortia, if they wished to share an accountable officer, to agree who they wished to take that role and to put that name forward.

I hope that that explanation of the various aspects of the amendments, and why they are in fact more than sufficiently dealt with by the provisions in this Bill, will reassure the hon. Lady and that on that basis she will withdraw the amendments. If I have not managed to persuade her—because this is one of those groups of amendments intended to undermine the Bill, rather than improve it—then I simply say that I urge my hon. Friends to oppose them.

Liz Kendall: I thank...[Interruption.]

The Chair: I must tell the hon. Member for Loughborough that she should not be calling across the Committee.
Liz Kendall: Thank you, Mr Hood. This has been the start of an important debate, which goes to the heart of the Bill. We have had contributions from Members who may support the Government’s direction of travel but have concerns, as well as from Members who oppose the direction of travel but also have genuine concerns.

Four key points were raised during the discussion. First, the hon. Member for Enfield North was keen to emphasise that he would be concerned if GPs were not directly involved in running the senior management of consortia. Currently, that is not a specific requirement in the Bill. It also relates to an issue that the hon. Members for Stafford and for Southport raised about the need to ensure that consortia involve other clinicians.

I want to point Members to recommendation 96 on page 30 of the Health Committee’s report:

“GP have an essential role to play as the catalyst of this process, and under the terms of the Government’s changes they...will have the statutory responsibility for commissioning. They should, however, be seen as generalists who draw on specialist knowledge when required, not as the ultimate arbiters of all commissioning decisions. The Committee will review the arrangements proposed as the Bill goes forward. That covers the first issues raised.

Paul Burstow: I think the hon. Lady is rehearsing the debate that we had last week, and she seems to be skating over the comprehensive response that I just gave her. I made it clear that we accept, first, the Select Committee’s point that GPs are clearly the catalysts, and, secondly, that GPs cannot subcontract within the consortia their responsibilities to discharge their duties.

Liz Kendall: I gently contend that the Minister’s answer was not comprehensive. He did not provide the reassurance that Opposition Members certainly require.

Paul Burstow: I am not rehearsing those arguments; I am referring, as one does when one sums up a debate, to contributions made by colleagues on the Committee.

The Chair: Order. We are at the beginning of what could be a very long day. I hope that hon. Members will not cause the Chair to keep jumping to his feet to get order following chuntering between Members on the same Benches or Members from opposing Benches. I make that point in the hope that I will not have to do so again.

Liz Kendall: The Minister certainly did not suggest that there would be any changes to the Bill—even those necessary to guarantee that what he says he accepts would be the case. I am not reassured on the point.

The second set of important issues, to which we will return during discussion on amendments to subsequent clauses, was raised by the hon. Member for Southport about the “inherent dangers in making the composition solely GPs” and the “genuine risk of self-interest in commissioning practices” — [Official Report, Health and Social Care Public Bill Committee, 3 March 2011; c. 508-9.]

The Minister said that provisions later in the Bill address the concerns, but I do not believe that they go far enough. Again, if hon. Members do not take my word for it, I point them to the Health Committee’s views in its report:

“The potential conflict of interest between consortia and local primary care providers does however remain. We therefore intend to review the arrangements proposed in the Bill for the commissioning of primary care services.”

That review has not been conducted yet, and I am sure that hon. Members will wish to see the report before they make final decisions about the Bill.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Has the hon. Lady actually read proposed new schedule 1A(4)(2) to the National Health Service Act 2006? It states:

“The constitution of the consortium “must, in particular, make provision for dealing with conflicts of interests of members or employees of the commissioning consortium.”

Liz Kendall: I am aware that the Bill says that that is what the constitution must do. In the Bill there are a huge number of ways—with the different duties, powers and responsibilities that consortia have—in which that issue must be explored more closely. I wish to come back to that at a later stage.

The third point was that made by my right hon. Friend the Member for Rother Valley and the hon. Member for Southport. It was about concerns over what happens if a GP practice folds. The hon. Member for Southport said that making the local NHS depend on such contingent events is not a stable model. The Minister gave a full and thoughtful answer to that query, for which I am very grateful, but I will examine his words in detail once they have been recorded by Hansard—[Interruption.]

The Chair: Order. I hope this is the last time I have to say that to the Minister.

Liz Kendall: Thank you, Mr Hood.

Mr Kevin Barron (Rother Valley) (Lab): Will my hon. Friend give way?

Liz Kendall: Goodness, yes.

Mr Barron: The Minister has covered potential areas where people might be able to sit on consortia, but last week we discussed in detail the conflict between—and, on occasion, within—GP practices, and the fact that they are not necessarily a solid base. The other conflict, which has run for many years in the NHS, is the stand-off there has often been between primary and secondary doctors. If secondary care doctors do not have a role to play unless they are invited, they may not be invited. What does my hon. Friend think of that?

Liz Kendall: I think that my right hon. Friend makes a very important point. I ask Ministers for greater reassurance on these points in the Bill, rather than just an assertion that something will be the case. My own experience of working in and around the NHS is that, as my right hon. Friend says, conflicts of interest between GPs, and between GPs and clinicians—particularly within the hospital sector—are real and must be addressed more fully.

Paul Burstow: I am very grateful to the hon. Lady for giving way, and to the right hon. Member for Rother Valley for his point. Of course, in discharging any of its functions, a GP commissioning consortium must have
regard for its duties, one of which is to seek appropriate clinical and other advice in enabling it to discharge its function. So secondary care doctors will be engaged because they have a part to play—that is a key part of the strength of these reforms.

Liz Kendall: We know that at present different parts of the NHS have duties to work together, but in reality—as I am sure the Minister knows, as he spends time in the NHS—asserting that there is a duty to co-operate and collaborate does not always mean that it happens.

The Minister of State, Department of Health (Mr Simon Burns): I am grateful to the hon. Lady for saying that, from her work in and with the NHS, she was aware of a problem with potential conflict of interest in certain circumstances. There were opportunities in the Health Acts of 2006 and 2009 to deal with things—rather than just using rhetoric like this morning’s—if there was a genuine problem. Why was nothing done when she was in a position to advise Ministers?

Liz Kendall: I am sure that the Minister realises that I was not a Member of Parliament when I worked in and around the NHS. I was not a Minister and I represented ambulance services, so I will not pursue that point any further. [Interruption.] The right hon. Gentleman is now in government, and the great joy and pleasure of this Committee is that we are scrutinising the current Government’s legislation.

Mr Burns: On a point of correction so that the Committee fully understands, I should say that from 2005 to 2007 the hon. Lady was actually the special adviser to the Secretary of State for Health.

Liz Kendall: I congratulate the Minister on an accurate comment.

Moving on, the fourth concern is about effective scrutiny by and accountability to patients and the public. At this juncture, I refer again to the Health Committee. The reason I keep referring to it is that, as a lot of Members know, the Select Committee has said that it is concerned to look at all the arrangements, and it will report on whether it believes that the Bill deals with some of the problems and challenges. We have not yet seen that report, although I am sure we will all be interested in what it says.

In its third report, under the heading “Patient and Public Engagement” in the section about the White Paper and the subsequent document responding to the consultation, the Health Committee states, at paragraph 117:

“However, neither this nor subsequent documents have detailed how patients or the public might participate within the governance structures of the commissioning bodies (for instance, by means of non-executive directors), nor whether there will be any degree of transparency in how those bodies operate at board level (for instance, in respect of holding their meetings in public).”

Paragraph 118 continues:

“The Committee does not find the current stance on patient and public engagement in commissioning persuasive. The...Committee regards the principle that there should be greater accountability by commissioners for their commissioning decisions as important. We therefore intend to review the arrangements for local accountability proposed in the Bill.”

The Minister has said nothing that answers those points, which is why I have raised the question of delegating responsibilities or functions to a committee or sub-committee, which could still allow contributions from other bodies and organisations—yes, from the voluntary sector and the private sector. I make no comment on the wisdom or otherwise of either of those; my focus is on accountability at that stage.

Owen Smith (Pontypridd) (Lab): I have been listening carefully to what my hon. Friend and the Minister said. The Minister made an important contribution to allay fears about consortia being able to subcontract important functions such as the principal function of commissioning. He effectively said that, to whomever the consortia subcontracted, the subcontractor would be banned from doing that under the duty to improve services placed on the consortia in new section 14L. That new section 14L binds the subcontractor acting for the consortium is, obviously, an interpretation by the Minister. However, I cannot find anywhere in the Bill an explanation of how that subcontractor is to be bound by the duty. What is my hon. Friend’s view? Will legal contracts be needed to bind the subcontractor? Is that what the Minister is saying? Otherwise, I cannot see where in the Bill his attempt to allay our fears is substantiated—

The Chair: Order. Again, interventions have to be more succinct than that. I call the Minister.

Liz Kendall rose—

The Chair: Sorry. I call Liz Kendall.

Liz Kendall: Thank you. If I were the Minister I would tell my hon. Friend about how to sort out some of the lack of clarity in the Bill, but, alas, I am not. Therefore, I say that how that provision will work is unclear.

Labour Members are so concerned about the issue because simply publishing a constitution, an annual plan and an annual report, even though they must be discussed at a public meeting, does not amount to effective governance and scrutiny. Hence the concern about delegating whole functions to committees or sub-committees, which might not be made up of the members of those boards.

Paul Burstow: First, the constitution will stipulate the nature of governance arrangements in much more detail than PCTs currently do, which will help the public and others to understand and better scrutinise consortia activities. Health overview and scrutiny committees will be able to call consortia to account in a way that does not currently exist.

On the issue that the hon. Member for Pontypridd raised with his hon. Friend the Member for Leicester West, the point is that, first, in subcontracting a function to be undertaken, the duties of the consortia must still be discharged, and the NHS commissioning board, in terms of its support to consortia—

The Chair: Order. I remind the hon. Gentleman that he intervened on the hon. Member for Leicester West, so he should not be responding to a previous intervention to her speech.
Liz Kendall: Having scrutiny from local authorities and a constitution are welcome, but that does not override the need for an effective board with non-executive as well as executive directors, which involves the full range of people necessary, publishes its agenda and meets in public.

Paul Burstow: The question of subcontractors being bound by consortia duties and where that is in the Bill is an important matter, and I want to ensure that it is clearly on the record. Consortia are still responsible for any subcontractor task; subcontractors act on behalf of the consortia. That is a matter of public law that is well established, so no specific reference to it is needed. Furthermore, there will be contractual support from the commissioning board in the form of draft model contracts for that sort of activity.

Liz Kendall: I thank the Minister for those comments, but my point is that the subcontractors may well have some kind of contract and be subject to the duties of the consortium, but if the consortium itself does not have effective accountability systems, that is a problem—that is the key issue.

Owen Smith: Despite the further reassurance we have had, does my hon. Friend agree that the constitution, which we are being asked to take on trust because we have not seen any version of what it might look like for a consortium, cannot cover all eventualities in respect of all the functions that might be subcontracted? Equally, even if a consortium is under a duty to deliver on its duties, it cannot guarantee that its subcontractors will do so.

Liz Kendall: Indeed, and I would add that, even if there were fairly regular scrutiny meetings with the local health and well-being board, that is not the same as having a board with non-executive directors who regularly scrutinise the work of the executive directors. That is why I am not reassured by the Minister’s response to the points raised, not only by Opposition Members, but by Government Members and the Health Committee. These are serious concerns. Whatever the Government say their intentions are, Members are looking for greater reassurance and a stronger guarantee that there will be accountability.

The purpose of amendments 175 and 176 was to say that if there were far stronger accountability and governance arrangements within consortia, allowing them to appoint their own accountable officers would be appropriate. In the absence of that, I would not want a situation in which the national board was unable to affirm them.

To conclude, I am disappointed that we have not secured any movement on these important matters.

John Pugh (Southport) (LD): The hon. Lady has not dealt with the point made by me and the right hon. Member for Rother Valley. Having GPs as the sole members of the board makes it, in a sense, impossible for local dentistry to be commissioned locally. Were there a broader concept of what the commissioning board will be, local dentistry could be commissioned locally.

Liz Kendall: Absolutely, and I beg the hon. Gentleman’s forgiveness for not covering that point. Our aim in tabling amendment 174 is to ensure that boards must include a wide range of different clinicians and practitioners from community services, including dentistry, pharmacy, as well as those working in secondary care, nurses and others.

I understand Government Members’ concerns about micro-managing the NHS. The amendment may not be perfect, but we want to strike a balance between ensuring that there are effective boards that have the right members, and that individual consortia are not micro-managed. The question is how we get greater reassurance in the Bill. My right hon. Friend the Member for Rother Valley said that he does not think that the amendment is completely right. I think he is correct, as are Government Members. We shall take the amendment away for further consideration and bring the matter back on Report. By that time we hope to have had the benefit of further thinking from Committee members on both sides and of the wise words of the Health Committee. We can all then be assured that GP-led commissioning consortia have the effective governance structures that they will need if they are to be custodians of £80 billion of taxpayers’ money. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Jeremy Lefroy (Stafford) (Con): I beg to move amendment 186, in schedule 2, page 227, line 29, at end insert—

(3) The consortium must make provision for its members individually to have the opportunity to decide the maximum number of patients they serve.’.

The amendment raises the question of general practice size. The Bill’s effectiveness will depend very much on the commitment of general practices, particularly small ones. I draw the attention of hon. Members to my declaration of interest, which is that my wife is a general practitioner. Arising from that, and from the evidence that the Committee has received, I was minded to table the amendment to discover the Government’s position.

In his evidence to the Committee, Dr Kingsland said that

“84% of GPs are independent contractors, and of the 16% who are not, half work with independent contractors. It is largely an environment of independently contracted, self-employed GPs who inherently have always wanted to produce a good practice and accept patients.”

Small practices often have the highest patient satisfaction ratings. In response to the same question, Dr Gerada said that the Royal College of General Practitioners values such practices, which

“often get the highest patient satisfaction. If you look at the research evidence and compare like with like, small practices do as well as large ones if you compare their make-up, but you have to accept that small practices tend to be in much more deprived areas, for lots of reasons.”

Many small practices are content with doing the work they do, and do not want to become larger. Traditionally, there have been two methods of limiting practice size: the first is to use the ability to close a list if it is believed to be getting too large for them to manage; the second is to restrict practice boundaries. Patients now have choice, and rightly so, but practices also need it. That does not mean the choice whether or not to accept a particular patient, which would be entirely wrong. I agree with Michael Sobanja, who said that he shared Dr Gerada’s view.
"that there should not be cherry-picking, and that neither practices nor consortia should be able to exclude patients because they are difficult or high cost."—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 45-47, Q98.]

However, I also agree that it is vital that general practices are able, within close reason, to choose how many patients they believe they are capable of serving to the highest standards. I want the Minister to give a clear statement that such choice will be available to practices.

Mr Burns: I am extremely grateful to my hon. Friend for moving this amendment, so that we can have a short and relevant debate on an issue that is very important to many GPs and patients. The amendment proposes that consortia should be able to develop internal arrangements so that individual members can set the de facto limit on the number of patients who can register to receive primary medical services from their practice. Such arrangements would be set out in the consortium constitution.

I am afraid that I cannot support the amendment for the simple reason that I believe it would create a substantial barrier to people’s ability to register at the GP practice of their choice. That is a principle to which the Government signalled a clear commitment in our White Paper, “Equity and excellence: liberating the NHS”. We wish to give every patient a clear right to choose to register with any GP practice they want to with an open list and without being restricted by where they live.

The amendment could allow arrangements to develop whereby practices could effectively close their lists. If all the practices within the consortia were to apply to close their lists to new patients to maintain the maximum population set by their consortia, where would those patients go for their care? I accept that is an unintended consequence of the amendment, but would create serious problems.

I point out that if a practice wishes to close its list, it must at present seek the approval of its PCT and, in future, that of the board. That is the proper way to do things because those organisations, not consortia, hold the primary care contract with individual practices. The amendment would create a requirement that would sit very uneasily with that.

Given my hon. Friend’s question about whether practices will have the choice to stay small, I repeat the straightforward answer that a practice could apply to the board to close its list if it wanted to. Provided that the board agreed that the practice could close its list, because the reasons were valid, that aim would be achieved, but it would be up to the board to determine the validity.

Mr Burns: I fully understand what my hon. Friend says. The fact is that the board would decide whether a practice was allowed to close its list. I cannot anticipate in what circumstances the board might refuse or agree to that because it will treat each case individually. It would be very unwise of me to try to anticipate why the board might make a decision either way.

Emily Thornberry (Islington South and Finsbury) (Lab): I am interested to know how the national commissioning board, from the viewpoint of Whitehall, would have sufficient information about a locality to be able to make a fine and nice decision in relation to whether a GP should close their list?

Mr Burns: From a number of debates and discussions we have had during the course of the Bill, I can tell the hon. Lady that it is because the commissioning board will not be a national ivory tower. As we have said, time and again, the board will be involved in the local health economy of the country: for example, though its involvement with the health and well-being boards, and its work with consortia throughout England. The board will be there to ensure that the health service in England is delivering as it is meant to, so I am afraid the supposition behind the hon. Lady’s intervention is not valid.

Emily Thornberry: Will the hon. Gentleman give way?

Mr Burns: No, because I have answered and there is not much more to say. I ask my hon. Friend the Member for Stafford, in the light of the points I have made, to consider withdrawing his amendment.

John Pugh: This excellent amendment has propelled me along a line of thought that had not previously crossed my mind. I have started to rehearse in my own mind how such a situation would be dealt with now. I am familiar with the situation in my own neck of the woods where, if a GP practice is not big enough or an area is under-doctored, the primary care trust plugs the gaps—it puts another organisation in place. It allows the practice to stay smaller than it wants, and in some cases brings in private providers or other GP practices.

What I am not clear about—the debate on the amendment has added to my general confusion—is what will happen when GP consortia are left with that role. What will happen when a consortium contains a practice which, for perfectly valid and clinical reasons—perhaps reasons of clinical safety—wishes to remain a certain size, does not wish to grow any further and cannot be coerced into doing so, but a gap in the system is emerging because of an influx of people into the area who are looking for doctors? Clearly, when the GP consortia are making that decision, they will consist entirely of local GPs—in a sense, we have a scenario where local GPs decide whether to invite another practice in to fill the gap, or to persuade one of the partners in the consortium to expand further. All those decisions are quite problematic in the current environment and in the environment created by the legislation, and I am intrigued by what will happen. The amendment has highlighted a lacuna about which we need to have clarity.
Jeremy Lefroy: I am grateful to right hon. and hon. Members and to the Minister for his response. As my hon. Friend the Member for Southport said, the matter in one about which there will probably be considerably more discussion. I reiterate that the present situation could be unsatisfactory, in that independent contractors—it is clear that they are independent—in effect, through the laudable policy of patient choice, will sometimes be required to extend their practice and their patient care further than they want. Perhaps one solution would be to make it easier for new practices to be set up in areas where existing practices are saying “Enough is enough.” As my hon. Friend said, and I believe the right hon. Member for Rother Valley has made the point before, there are areas, particularly in inner cities, that are under-doctored. I will certainly withdraw my amendment—because I had no intention of pressing it, but tabled it simply to raise the issue.

John Pugh: Has my hon. Friend had my experience—I think it is probably shared by most members of the Committee—of asking local pharmacists in an area, “Do you think we should have another pharmacist?” or the local dentist, “Do you think we should have another dentist?” and almost invariably receiving the answer, “No.”? If we are to ask local GPs, “Are we under-doctored? Do we need another doctor?” I think the answer would be obvious.

Jeremy Lefroy: I certainly accept that. However, there is an absolute requirement for everyone in a consortium area to have a doctor—to be registered. That is a legal requirement. The consortium would therefore be required to ensure that there were sufficient primary practices for every patient in that consortium area to be registered. I think the problem could be overcome in that way. Local doctors might be unwilling to see another practice come in, but they would simply have to put up with it doing so if they were not prepared to take the patients on to their own list. That is the other side of the coin.

It comes down to patient choice, which I fully support. I underline the fact that practices should not in any circumstances be allowed to choose or cherry-pick their patients, but they should have the right to determine the number of patients to whom they are capable of providing the high-quality care that we so need if the Bill is to be a success. Single-handed and small practices are an integral part of that delivery of care and I would hate to see them put under pressure to grow larger or to disappear. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 153, in schedule 2, page 228, line 6, after ‘such’, insert ‘suitably qualified’.

The amendment speaks for itself—it seeks to ensure that those employed by consortia are properly qualified. We will have an opportunity to discuss employment by consortia further under the next group of amendments.

Mr Burns: As the hon. Lady has briefly and eloquently outlined, the amendment seeks to ensure that consortia staff be “suitably qualified.” Aside from the fact that that is a nebulous term, without definition, general practice-led commissioning consortia have a duty to act effectively in everything that they do. I cannot see how a consortium would be able to carry out such a duty without its staff being suitably qualified. What business would be foolish enough to employ people who cannot adequately fulfil the job description? For that reason, I hope she will withdraw the amendment.

Emily Thornberry: That is not the answer that we wanted to hear—we had hoped for a more detailed one. However, the amendment was probing, and if that is all I am going to get, I beg to ask leave to withdraw it.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 154, in schedule 2, page 228, line 9, after ‘determine’, insert ‘having due regard to the NHS pay scales agreed following recommendations by the NHS Pay Review Body and the Doctors and Dentists Pay Review Body, or any successor bodies’.

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

Amendment 155, in schedule 2, page 228, line 11, after ‘determine’, insert ‘having due regard to agreements made by the NHS Staff Council’.

Amendment 156, in schedule 2, page 228, line 16, at end insert—

‘(4A) Regulations under subsection (3) and guidance under subsection (4) shall also apply to any person with which the consortium enters into a contractual agreement relating to the exercise of its functions, including the employees of such a person, in so far as they are exercising the functions of the consortium or assisting the consortium in the exercise of its functions.’.

Amendment 157, in schedule 2, page 228, line 21, after ‘schemes’, insert ‘having due regard to the provisions of the NHS Pension scheme’.

Emily Thornberry: The purpose of the amendments is to ensure some protection for staff when they are transferred, rather than leaving terms and conditions, pay and pensions entirely to the whim of the consortia. The pay review boards of the NHS and of doctors and dentists are independent bodies and are respected by staff and employers alike. Their independence and credibility should be maintained in the new system. Likewise, the NHS staff council brings together organisations from across unions and employers.

We want to ensure that reasonable terms and conditions apply also when a consortium outsources work to another organisation, rather than letting a different employer—potentially a private company—exploit inferior terms. When we talk about the NHS, we all know that what are most important are the quality of care that patients get and the staff within the NHS. The amendments are important to ensure proper terms and conditions for staff.

Mr Burns: The amendments seek to ensure that consortia employees’ pay terms and conditions are comparable to those of the NHS and other public sector workers and that GP-led commissioning consortia cannot employ people on private sector conditions. I fully understand the motivation behind the amendments, but I am not convinced that they are necessary.
Amendments 154 to 157 would require consortia to have regard to NHS pay scales, pay reports, and terms and conditions agreed by the NHS staff council and the NHS pension scheme. We must bear in mind that where a function transfers from one employer to another, the Transfer of Undertakings (Protection of Employment) Regulations 1981 and 2006 may apply. Additionally, any transfers of staff from the public sector must appropriately apply the principles of the Cabinet Office statement of practice on transfers involving public sector staff. The transfer of undertakings regulations require that staff terms and conditions at the point of transfer be protected. The Cabinet Office statement of practice contains additional protections regarding pensions, which will ensure that staff do not lose out if they are to transfer.

Under clause 23, consortia will have a ring-fenced administration budget, which they have the freedom to spend on such administrative functions as they determine, including staff salaries. To attract and retain the best staff, consortia must be free to remunerate as they determine, within the confines of their budgets. Consortia would, of course, be required to publish information relating to remuneration. Paragraph 8 of schedule 2 contains a regulating-making power to achieve that.

11.30 am

On pensions, referred to in amendment 157, we intend that GP commissioning consortia be classed as employing authorities for the purposes of access to the NHS pension scheme. As such, staff employed by consortia will be enrolled automatically and able to participate fully in the scheme. We intend to amend the NHS pensions regulations, with effect from April 2012, to include GP consortia in the definition of an employing authority.

Amendment 156 would affect a consortium’s ability to engage support for its functions. Making each contractor employed by a consortium subject to the same guidance and regulations as direct employees would be extremely impractical. Contractors’ pay levels may be made publicly available, and the guidance on pay levels might prove uncompetitive. Where expertise is best sourced from outside the consortium, it is essential that the consortium can secure it, and at market rates. The two amendments could prejudice that. Furthermore, amendment 156 would restrict the well established principle of freedom to contract within the common law. That could leave consortia at the risk of judicial review.

For those reasons, I invite the hon. Member for Islington South and Finsbury to withdraw the amendment. If she is minded to press any of the group to a Division, I invite my hon. Friends to join me in opposing them.

Emily Thornberry: I approached the amendments with an entirely open mind about the issues. I was hoping to get reassurance from the Minister but, if anything, I have been increasingly alarmed by what he said. The fracturing of the national health service would seem to result, as night follows day, in the fracturing of terms and conditions. Given that we have not had appropriate reassurance, I wish to press the amendment to a vote.

Mr Burns: I beg to move amendment 106, in schedule 2, page 229, line 6, leave out ‘and 13’ and insert ‘to 14’.

The amendment makes a minor change to schedule 2, which inserts new schedule 1A into the National Health Service Act 2006. Schedule 2 makes further provision about consortia. Paragraph 9 of new schedule 1A sets out the duties of a consortium’s accountable officer. The accountable officer is a key leadership position within a consortium and is responsible for ensuring that the consortium exercises its functions in a way that provides good value for money while complying with certain obligations. The consortium as a whole will, of course, be responsible for complying with all duties conferred on it by the 2006 Act through the Bill. However, there are certain obligations which it makes sense to attach specifically to the accountable officer’s role. Doing so will ensure that there is a clear reference point with regard to accountability in respect of the obligations.

At present, the accountable officer is responsible for ensuring that the consortium complies with its financial, accounting and auditing duties, and exercises its functions in ways that are efficient, provide good value for money and aim to secure continuous improvement in the quality of services provided and outcomes achieved. The accountable officer is also responsible for ensuring that, if requested, the consortium provides the board with certain information relating to its accounts, income or expenditure, or its use of resources. That allows the board to hold consortia to account for their finances and, in turn, enables the board to account to the Secretary of State for how funds have been spent across all consortia.

The amendment would extend the responsibility so that the accountable officer must also ensure the consortium complies with its obligation under paragraph 14 of new schedule 1A to provide the board with such information as the Secretary of State may require from all consortia, as opposed to from a single consortium or group of consortia. On the basis that he considers it necessary to receive that information to carry out his functions in relation to the health service. The board would be required to relay that information to the Secretary of State.

Question put, That the amendment be made:—

The Committee divided: Ayes 11, Noes 13.

Division No. 26]

AYES

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

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

NOES

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

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

Question accordingly negatived.
State, who accordingly would have no direct contact with consortia. Given that the Secretary of State must consider any such requested information to be necessary to enable him to perform his functions, it is appropriate that ensuring that it is provided forms part of the accountable officer's responsibilities.

Amendment agreed to.

Emily Thornberry: I beg to move amendment 158, in schedule 2, page 232, leave out lines 16 to 20.

The purpose of the amendment is to remove the explicit reference to employers altering the terms of a transfer after it has taken place. In extenuating circumstances, that can already happen for an economic, technical or organisational reason, so there is no need to put it in the Bill. The health service unions would be hugely reassured if the reference were taken out. As it is already in legislation, why does it need to be underlined in the Bill? All the provision does is act as an encouragement for some employers who want to unravel the terms of staff transfer after the fact.

Mr Burns: Amendment 158 would restrict flexibility in staff and property transfer schemes that are created by the board in instances where consortia dissolve, merge or vary their membership. There might be occasions where it is practical to include provision in a scheme to make it possible to amend that transfer scheme when it is already in effect, and we wish to retain the ability to do so. An example of where a modification would be needed might be if, due to an oversight or error, a property or liability was not initially identified as requiring transfer.

The key words in the passage that the amendment would omit are “by agreement”. That is the check and balance on the exercise of the flexibility by the board. It goes without saying that any such agreements would have to be agreed by both parties concerned. Quite simply, where no agreement can be reached, the board have to be agreed by both parties concerned. Quite goes without saying that any such agreements would balance on the exercise of the flexibility by the board. It

Amendment 140, in clause 22, page 30, line 36, at end insert 'and from persons with professional expertise in patient and public involvement and review and scrutiny.'.

Amendment 170, in clause 22, page 30, line 43, leave out from second 'are' to end of line 44 and insert 'consulted'.

Amendment 141, in clause 22, page 31, line 19, at end insert—

'(7) Consortia must have regard to the outcomes resulting from arrangements made under subsection (2) when exercising their functions.'.

Amendment 142, in clause 22, page 31, line 19, at end insert—

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

Amendment 144, in clause 22, page 34, line 10, after '14L', insert 'and 14P'.

Amendment 147, in clause 22, page 35, leave out lines 7 and 8 and insert—

'(b) make arrangements for the annual report to be drawn to the attention of patients and the public and their representatives, including holding a meeting or meetings for the purposes of presenting the report and for receiving the views of patients and the public and their representatives on the consortia’s assessment of how its functions have been discharged.’.

Amendment 148, in clause 22, page 35, line 17, after '14L', insert 'and 14P'.

Amendment 214, in clause 22, page 36, line 35, after 'Board’, insert ‘after consultation’.

Emily Thornberry: We have dealt with the establishment of the commissioning consortia, and we have expressed our concerns about their inadequacies, particularly in terms of their public accountability. The clause deals with the way in which, once established, the board behaves in relation to the public. It gives the commissioning consortia a duty to promote patient involvement, to consult, through an overview and scrutiny committee or otherwise, consortia shall include in their arrangements under subsection (2) when exercising their functions. It gives the commissioning consortia a duty to promote patient involvement, to consult and involve the public. Those duties all sound very nice, but a line-by-line analysis shows the provision to be inadequate.

Alert Members will have noticed that amendment 138 is remarkably similar to amendment 133, although it applies to commissioning consortia rather than the NHS commissioning board. Amendment 139 is remarkably like amendment 134, and amendment 140 is remarkably like amendment 135. Amendments 133 to 135 were right for clause 19 and amendments 138 to 140 are right for clause 22. Given how much we have to go through, I do not think I need to go through the arguments again.

Amendment 170 addresses public involvement by the commissioning consortia. Proposed new subsection 14P(2) states:

“The consortium must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)”.

That proposed new subsection is full of unnecessary weasel words and may simply result in a leaflet on a desk, which could be the extent to which the public are consulted, considered or given information. We do not want commissioning consortia to wriggle out of it; we want to hear from the Minister the extent to which the
Government expect the public to be properly consulted. That is the reason for the amendment, and I would like to have his reassurance that proposed new subsection 14P(2) will not mean a leaflet on a desk. [Interruption.] From a sedentary position he says it will not, but let us have it on the record.

Amendment 141 is a classic amendment. There is always a problem with consultations in that people feel the consultation is an end in itself. Given the Government's focus on outcomes, the amendment would ensure that the Government are not only saying that people will be consulted, but listening to what people say and learning from it, which is an important part of consultation.

When the Minister responds to this group of amendments, perhaps he will be able to have another stab at the distinction made between patients and the public. Could he tell us what the difference is and how we can work on a definition? The Bill talks about patients at one point and the public at another without defining either. Presumably patients are part of the public, but the public are not always patients. So I would like the Minister to make another attempt at providing a fuller definition.

The Minister has said that the consortia will be held to account by overview and scrutiny. It is our view that the extent to which consortia can be held to account is weak. Amendment 142 would beef that up. If the Minister's ambition is that commissioning consortia are accountable to overview and scrutiny, I cannot see why he should object to this amendment, which simply beefs up his aspirations and ensures that they are included in the Bill. The amendment would make the Bill better.

Amendment 144 is about publishing an annual plan. When the annual plan is published, we say that the annual plan from the GP consortia should include how they have involved the public. If they are reporting once a year, they should report specifically on that issue.

The most important point about amendment 147 is that the annual report should not just be the commissioning consortia telling the public once a year what they are going to do; they should also receive the views of patients and the public and their representatives on the consortia's assessment of how their functions will be discharged. We should not just be there to tell them; we should be there to listen as well and to learn from what they say. If Government Members are so keen on ensuring that GP consortia are properly accountable to the public, I cannot see what the objection to that will be. It is a shame that it was missed out of the legislation in the first place, but we are here to help.

Mr Burns: Oh yeah?

11.45 pm

Emily Thornberry: With these, we are here to help. Amendment 148 is about the performance of consortia. When the performance of consortia is assessed, we believe that that assessment should include whether or not they have properly involved the public and whether they have properly consulted them.

Amendment 214 reflects our view that the board should consult properly before a commissioning consortium is dissolved.

John Pugh: I was asked by the Patients Association to be chair of the all-party group on patient involvement in health and social care and representatives came to see me some weeks ago making the point that they had canvassed a number of the pathfinder areas and asked the GPs what their public engagement strategy was and what plans they have. They had various responses, which I am sure they will publish in the fullness of time, but they were not completely satisfied with the answer, nor did they have any indication that the Department of Health had asked for one.

I brought this up with the Secretary of State, who made the sensible point that the consortia have enough to do at the moment without being asked to have all their documents lined up in order, which I totally accept. However, the Patients Association wanted to make a serious point, which is that, for many doctors, this will involve a huge culture change. Going out and engaging with the general public in their area is not something that they customarily do. They are normally snowed under with dealing with day-to-day clinical matters and therefore, except in the more progressive, imaginative practices, they are now being pressed to do something completely new and the priority has to be stressed to them, put across to them, as to what the Government expect them to do. Loading them with various book exercises to complete and various documents to produce may not be the most satisfactory way of doing it, but I want to put on record that the Patients Association have a genuine concern as to how real patient and public engagement will be conducted under the new regime, given that doctors have not really done this before.

Mr Burns: I was delighted to listen to the hon. Member for Islington South and Finsbury on two counts; first, because she made it clear that these amendments were not meant to undermine the Bill—at least we know where we stand; and secondly, because she said that she was trying to be helpful, though I am always cautious of people who try so blatantly to be helpful when they have not been helpful in the immediate past. There is a saying in America—I hasten to add that it is from America, so that it is not misunderstood—“I’m from the Government and I’m here to help” and the meaning is always the opposite. I feel, somehow, that that is the real attitude of the hon. Lady, however nicely she has made her points.

Let me start by reassuring hon. Members that public accountability is, rightly, at the heart of the Government’s vision for the NHS. We passionately believe in devolving power and responsibility to local GPs to strengthen commissioning through a patient-centred approach. We have therefore included a clear duty on consortia to engage with patients and the public on an ongoing basis as they undertake their commissioning responsibilities.

I welcome the hon. Lady’s interest in public involvement. However, as I deal with the amendments in turn, I hope that she will realise that they are unnecessary. Amendments 138 to 140 aim to increase public involvement and involve similar concerns to those expressed by the Centre for Public Scrutiny.

Emily Thornberry: That is right.

Mr Burns: The hon. Lady rightly acknowledges it. Amendment 138 is already provided for in section 14P. The amendment seeks to place a duty on consortia to
promote public involvement in decisions about the services that are to be commissioned for their area. The duty in 14P is in fact stronger than a duty to promote, and requires that consortia must involve patients in commissioning decisions. I hope that she will be reassured on that point and realise that I am helping her more than she is helping me with the amendment.

Owen Smith: In the spirit of helpfulness, can the Minister help me out by telling me whether 14P also applies to new section 14Z7, which refers to the procedural requirements in respect of dissolution of a consortium? I do not see that under 14Z7, the board is under any duty to consult the public before it dissolves a board.

Mr Burns: I am not going to avoid answering the hon. Gentleman, but I will be slightly careful, as I have learned my lesson about answering speculative questions from hon. Members that seem innocent enough but turn out to be fairly lethal in how they are misunderstood.

Derek Twigg: It is a compliment.

Mr Burns: I did not take it as one, but I am grateful to the shadow Minister. I repeat that amendment 138 seeks to include a duty on consortia to promote public involvement in decisions about the services that the consortium is providing. It is a proactive approach to the services provided by a consortium.

Emily Thornberry: Will the Minister give way?

Mr Burns: No, unless the hon. Gentleman wants me to give way to the hon. Lady to help him.

Owen Smith: Dissolution?

Mr Burns: I would rather wait until we discuss dissolution in detail rather than start answering hypothetical questions at this point that might be misconstrued. I certainly do not want to dodge the issue, but I will answer at the appropriate time.

Emily Thornberry: Will the Minister give way?

Mr Burns: No. I think that it would be fair to move on, as I suspect that the hon. Lady will try to tempt me down the same route that the hon. Gentleman did.

Amendment 139 seeks to add a definition of the word “public” as it features in the clause. However, it is not necessary, as new section 14P already includes a duty to involve the public. We demonstrate in the Bill the importance of putting people at the heart of decisions about the provision of health and care services. We refer throughout to “patients and their carers”, “individuals to whom services are being or may be provided” and “public involvement”. The public are at the centre of the reforms.

New section 140 of the 2006 Act imposes a duty on consortia to make arrangements with a view to securing appropriate advice from those with professional expertise relating to physical and mental health in order to enable them to discharge their functions effectively. Amendment 140 would require consortia, in carrying out that duty, also to make such arrangements to seek advice from those with professional expertise in patient and public involvement and review and scrutiny. However, the amendment would increase prescription and prompt the question why we had singled out one group over others. It returns to a problem that we discussed in relation to other amendments earlier in the Bill.

As we also discussed in relation to clause 19 and the NHS commissioning board, we recognise the valuable role that scrutiny has to play in providing transparency, accountability and local challenge, and our proposals adequately reflect that. Amendment 142 seeks to ensure that the commissioning arrangements for consortia are covered by local authority scrutiny functions. Section 244 of the 2006 Act is amended by clause 175 to provide powers to make regulations on scrutiny, including matters relating to the health service on which local authorities may make reports and recommendations to relevant NHS bodies. Paragraph 129 of schedule 4 to the Bill inserts a definition of NHS body that includes a commissioning consortium. This would therefore enable us to ensure that consortia were properly covered by local authority scrutiny powers.

Amendment 170 would specify that consortia must consult with individuals to whom the services are being or may be provided. Under the new arrangements, consortia would have flexibility in determining their own approach to involving the public. The effect of this amendment would be to remove that flexibility by requiring any engagement to take the form of a consultation. As drafted, the Bill places a duty on consortia to make arrangements for public involvement and consultation, but we would wish consortia to retain flexibility in deciding their approach. I therefore urge the hon. Member for Islington South and Finsbury not to press amendment 170 because I do not expect the fulfilling of this part of the Bill simply to involve popping a piece of paper on someone’s desk. We expect full and proper consultation in the spirit of greater transparency and accountability within the legislation.

Amendment 147 seeks to extend the requirement in new section 14Z for consortia to hold a public meeting to present their annual report. It would place obligations on consortia to publicise their annual report, hold at least one meeting to present it to the public and receive views on how they have discharged their duties. As drafted, the Bill already requires consortia to hold a public meeting at which their annual report would be presented to members of the public. How a consortium goes about this is not something for the Secretary of State to micro-manage. I assume hon. Members would agree that consortia should be able to develop ways of working with their communities that make sense locally.

Freedom and flexibility is what we are trying to create here. Amendment 141 seeks to make it explicit that consortia must have regard to the outcome of public involvement activities when exercising their functions. This is not necessary. Meaningful consultation is about involving the public and also letting them know the results and action being taken forward from those consultations. The public will be able to find out more about those results in consortia annual reports. We have placed a duty in new section 14Z subsection 2 requiring consortia to report on how effectively they have discharged their duties on public involvement and consultation.

I will take amendments 144 and 148 together as my response applies equally to both. Amendment 144 seeks to add the duty of public involvement to the list of duties that consortia must explain, via their annual
commissioning plan, how they intend to discharge. In a similar vein, amendment 148 proposes to add the public involvement duty to the list of duties that the board will review when annually assessing consortia performance.

New sections 14Y and 14Z1 explicitly state that both the scope of commissioning plans and performance assessments automatically include the whole range of consortium functions. Consortia will be required to produce a commissioning plan before the start of every financial year that describes how they will go about their functions in the coming year. Similarly new section 14Z1 defines performance assessment as being an assessment of how well the consortium has discharged its functions during the previous financial year.

12 noon

The purpose of the list of duties in proposed new sections 14Y(2) and 14Z1(3) is to highlight the key accountabilities of consortia: accountability for improvement in service quality, and for effective management of public funds. After all, let us not forget that the purpose of consortia is to deliver better health outcomes for local populations. That is not to underplay the other duties placed on them; if they were not important, they would not be in the Bill at all.

Amendment 214 concerns the board's powers to intervene in the operations of consortia. Under proposed new section 14Z6, if the board is satisfied that a consortium is failing, has failed, or is at significant risk of failing to discharge any of its functions, the board has powers to intervene in the operations of a consortium. That includes directing the consortium as to the discharge of its functions, terminating the accountable officer's appointment, and appointing another person to be accountable officer to ultimately dissolve a consortium.

Amendment 214 seeks to amend subsection (1) of the new section so that the board can intervene only after consultation.

Let me be clear that the board will have the power to intervene only where there is evidence that consortia are failing or are likely to fail to fulfil their functions. It must be satisfied of that before it exercises the powers. To that end, the Bill provides the board with powers to require documents and information from a consortium where it has reason to believe that a consortium might have failed, might be failing, or might be at risk of failing to discharge any of its functions.

Grahame M. Morris: Will the Minister clarify his definition, or define failure? Is it failure to perform in financial terms? Has his Department made any assessment of such a failure rate?

Mr Burns: My definition of failing will cover a number of things, including potential or possible financial failure, but in other areas, failings could be in the quality or standard of care, or there could be a failure to increase the quality or standard of care that a consortium is providing. To give an all-embracing definition, failure is to fail to perform one's functions. That is not only financial, and it is not only about the provision of care, the quality of care, or improving outcomes; it is across the board. I hope that is helpful.

Owen Smith: Does the Minister accept what we heard in evidence a couple of weeks ago—that it will be much harder to determine whether there is failure or improvement in respect of quality, because quality is so much harder to measure than financial arrangements? Is not the danger that the financial arrangements will become the most salient issue when it comes to measuring whether consortia are achieving their objectives?

Mr Burns: This may come as a surprise to the hon. Gentleman, but I do not accept his premise. Given the accountability in the Bill, the mechanisms that are in place, the role of the health and well-being boards, the role of HealthWatch, and the role of the national commissioning board, I do not think that the situation to which he alludes will come about.

Grahame M. Morris: Will the Minister give way?
Owen Smith: Will the Minister give way?

Mr Burns: May I deal with these points first, please? The hon. Member for Islington South and Finsbury returned to an issue that she raised earlier in proceedings: the definition of “patients” and “public”. Patients are persons who have been provided with services; if she looks at proposed new section 14N, that will help. The public are persons who may be provided with services, but need not be registered patients. The reference is in proposed new section 14P, if that is helpful to her. “Public”, for obvious reasons, goes wider than “patients”. As she rightly said, patients will be members of the public, but not all members of the public are necessarily patients.

On the information that the hon. Member for Southport was talking about, may I reassure him that we will shortly publish guidance that I think will be extremely helpful. I am sorry that it is not yet available, but it will be shortly. I hope that it will help him and provide a lot more information, not only to the Committee but to those outside this room.

Owen Smith: I come back to the point I raised earlier; I think this is the appropriate point, as the Minister mentioned proposed new section 14Z7. I asked about dissolution. Is the Minister suggesting that the duties under proposed new section 14P bind the board to consult with the public if it is taking the unusual step of dissolving a consortium? Furthermore, does he not agree that it would be helpful to include in the Bill an obligation on the board to consult with the staff in the event of a consortium being dissolved? I find the omission of that obligation very strange.

Mr Burns: The hon. Gentleman is correct—we have now come to the relevant point and I can give him an answer about that. New section 14Z7 states that the board must consult “any other persons the Board considers it appropriate to consult.” Therefore, the board can consult the public on consortia dissolution and, with regard to the second part of the hon. Gentleman’s intervention, such other persons as the board considers appropriate will clearly include staff. I hasten to add that that is in addition to a requirement that it has to consult the consortium and relevant local authorities.

Owen Smith: One more time?

Mr Burns: One last time. I think that I have been immeasurably helpful and clear.

Owen Smith: I am absolutely seeking to be helpful.

Mr Burns: I think not.

Owen Smith: No, I am. I am reassured by the Minister’s suggestion that the phrase “any other persons” must include staff and the public, but that is not my reading of it. My understanding is that it may include staff and the public. It would be helpful, therefore, to include staff in particular and also the public in the Bill to rule out any misinterpretation.

Mr Burns: Go on—accept it.

Mr Burns: I do not think I need to. New section 14Z7(1) states that the board must consult the consortium and its staff, which I would have thought met the point. [Interruption.] I think it does.


Mr Burns: I do not think that the hon. Member for Pontypridd understands the point I am making. What the proposed new section says is that the board must consult the consortium, which will include its staff. The consortium is an entity with a number of parts to it, and it would be inconceivable were the staff not to be consulted under the requirement to consult the consortium.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): There is a great distinction between the consortium and the directors of that consortium and its staff, employees or contractors. That clause should pay some regard to employment law and recognition agreements, which will obviously be carried over from the existing PCTs or other structures to these new consortia.

Mr Burns: Perhaps I am more of an optimist than the hon. Gentleman. I have to tell him that I am satisfied with this because, in reality, and given the requirements to consult the consortium, staff will be included and that is sufficient. It is for those reasons that I urge the hon. Member for Islington South and Finsbury to be suitably reassured and withdraw her amendment. If she will not, I ask my hon. Friends to join me in opposing it.

Emily Thornberry: Where to start? The Minister refers to the Centre for Public Scrutiny, and he recognises that many of these amendments come from that body. There have also been attempts, behind the scenes, to speak to the Government about the amendments, which represent a genuine attempt to get the Government to accept amendments that will properly give the Bill some form of democratic legitimacy. It is unfortunate, therefore, that the Government’s apparent attitude is not to give an inch on any amendment, no matter how genuinely reasonable or helpful, which is a shame. When the Minister and Government Members talk about the importance of introducing greater accountability and democracy to the national health service—sometimes in fairly florid language—they find friends on the Opposition Benches. However, the question is whether you are actually going to do such things or are using them as a smokescreen.

12.15 pm

The Chair: Order. I am not doing those things.

Emily Thornberry: Clearly not, Mr Hood. Are Government Members using these things as a smokescreen? That is the question. When amendments are tabled and dismissed in the way they are, the question sometimes arises as to whether Government Members are being genuine when they say they want to introduce greater accountability, and that is particularly true of issues such as GP consortia. GPs do not have a history
of consulting the public or being democratically accountable—that is not part of their culture or how they function. If we are to ask them to change their culture, we need to ensure that the legislation is tight and carefully considered, but I suggest that it is not.

Nick de Bois (Enfield North) (Con): Listening to that point, I feel that the hon. Lady is, uncharacteristically, persisting with an argument that the evidence does not support. Clause 175 extends health scrutiny to NHS bodies and beyond what it is now. We specifically specify GP consortia in subsection (4) on page 148. That is a massive step forward. It is probably uncharacteristically unfair of the hon. Lady to suggest that the Government are lying back and talking about these things without believing them.

Emily Thornberry: But if the Government wish to introduce greater accountability and democracy at the level of GP consortia, why not allow health and well-being boards to work properly with GPs to establish their annual commissioning plan—[Interruption.] Well, hon. Members roll their eyes and wave their arms, and they pay lip service to these things, but the purpose of the amendments is to ensure that there is a proper connection between health and well-being boards. The boards are a good idea in principle, but they simply do not have sufficient teeth or sufficient power in relation to GP consortia. That is the link we are attempting to establish, as we are on overview and scrutiny. That is a simple point, simply put. The Government should look again at this issue. Obviously, they can be assured that we will return to it at another stage.

The Minister talks about key accountability, but he gives the game away in a way. Of course we agree that key accountability in relation to GP consortia should be about improving services and giving greater value for money. Those are the two points that he made, but he did not go on to state that the other aspect of key accountability was democratic accountability at a local level. The only time he prays that in aid is when he is challenged on whether there will be quality improvements. To prove that, he says, “Well, of course there will be greater accountability, so there will be an increase in quality.” “The Minister simply needs greater education on this before he can promote the Bill properly. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 207, in clause 22, page 30, line 33, leave out from ‘arrangements’ to end of line 36 and insert ‘for the involvement of relevant clinicians from—
(a) community, primary or secondary care,
(b) professions allied to medicine,
(c) pharmacists,
(d) representatives from patients’ groups, and
(e) other persons with experience relating to the physical or mental health of individuals.’.

New section 140 of the 2006 Act relates to a consortium’s duty to obtain appropriate advice. It says that a consortium “must make arrangements” to obtain appropriate advice to enable it “to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals.” We have covered this territory before, so I shall be brief.

For a consortium to discharge its functions properly, it needs not just the advice of a range of unspecified professionals, but the genuine involvement of a range of professionals. The amendment seeks to ensure that consortia involve—not just ask for advice from—relevant clinicians from community, primary or secondary care; professions allied to medicine; pharmacists; representatives from patient groups; and other persons with experience relating to the physical or mental health of individuals. We hope that that would enable the involvement of a range of different people, such as dentists.

Mr Burns: Amendment 207 would amend proposed new section 140 of the National Health Service Act 2006, and I presume that it is intended to supersede amendment 140, which also sought to amend the section. The new section is inserted into the Act by clause 22 and it imposes a duty on each consortium to “make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical and mental health of individuals.”

The amendment proposes that the duty should set out more explicitly the particular types of experts from whom consortia would be required to obtain advice in order for them to discharge their functions effectively.

I understand the hon. Lady’s arguments, because they relate to how consortia can ensure that they make the most effective commissioning decisions, and I agree that the key will be how consortia obtain advice from a number of other interested parties. However, as she will know from our previous debates, the Government’s position is to give bodies the autonomy to make the decisions that they are best suited to make themselves. In this case, that includes allowing consortia the flexibility to obtain appropriate advice to enable them to perform their functions effectively. It remains our view that consortia will find it impossible to secure improving health outcomes without the right advice. Effective commissioning will require the full range of clinical and professional input alongside that of local people.

We have not sought to specify in the Bill exactly what professional advice consortia should take. It is for consortia to decide, and we have trust in them doing so. I am happy to confirm again that, although it is our intention that consortia should obtain advice from appropriate clinical professionals to enable them to discharge their functions effectively, I do not think it is appropriate or necessary to set out in the legislation the form that that should take. For those reasons, I oppose the amendment.

Liz Kendall: We try and will continue to try to get the Government to see sense and, on a more formal basis, require consortia to involve different groups on their boards, but at this stage I shall not press the amendment to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 159, in clause 22, page 30, line 36, at end insert—
‘140A Duty to consult staff
(1) Each commissioning consortium must have regard to the NHS Constitution, as legislated for in section 1 of the Health Act 2009, including the responsibility to engage staff in the exercise of its functions and to engage staff on changes that may affect their working practices.'
(2) Each commissioning consortium must publish a staff engagement strategy in relation to commissioning, including—
(a) developing and implementing commissioning strategies;
(b) reviewing services and care pathways;
(c) developing service specifications;
(d) procurement of services.
(3) Each commissioning consortium must engage regularly with staff representatives through local or regional Social Partnership Forums, or similar bodies, or any successor bodies.

140B Duty to work in partnership

Each commissioning consortium must seek to work in partnership with employers and staff side representatives in implementing new contracts, particularly where this would involve transfers or other changes that could affect working practices.

Touched as we were by the Minister’s optimism in relation to the establishment of consortia, we believe that the amendment may be necessary on the basis that they might not be autonomous workers’ collectives. The procurement guide for commissioners was rewritten by the Department of Health in the light of last summer’s White Paper, and much of the wording in annexe B on engagement with staff and their trade unions is similar to that of the amendment. The amendment is, therefore, designed to do nothing more than ensure that commissioning consortia abide by established Government practice.

The work of the NHS Social Partnership Forum has developed many positive initiatives for partnership-working throughout the country in recent years, and those successes must not be lost. For example, recent research by Aston University for the Department of Health demonstrated the considerable alignment between strong consultation of staff and high standards of care, which, ultimately, is what we all want. Conversely, at the Mid Staffordshire, where appalling lapses in care were revealed, there was a concurrent breakdown in staff involvement and engagement.

The first part of the amendment would oblige consortia to engage staff, in line with the constitution. It would also require them to produce strategies to show how they would engage staff in different parts of their operation as a means of improving patient care. It acknowledges the importance of partnership working and the SPF process, the local working of which could be lost when strategic health authorities are abolished, as those are often the places in which regional SPFs are based. The second part of the amendment would explicitly require consortia to engage staff when changes are made to contracts or through transfers that would impact on working practices.

This is a serious amendment, and we would wish to have proper answers to those points; otherwise, we will need to press it to a vote.

Mr Burns: The amendment would impose an extensive duty on consortia to consult their staff regularly and to publish a staff engagement strategy. It also seeks to ensure that consortia have regard to the NHS constitution. It is fortunate that it mentions the NHS constitution: I am sure that I do not need to remind the Committee that there is a general duty for the bodies listed in the Health Act 2009 to have regard to the NHS constitution. The Bill amends that regard to ensure that the NHS commissioning board and consortia are also captured by that duty. Hon. Members can find that in paragraphs 74 and 75 of schedule 5 to the Bill.

The current NHS constitution already includes the pledge to “engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.”

The amendment would therefore duplicate existing provision. For that reason, I hope that the hon. Lady will withdraw it rather than press it to a vote.

Emily Thornberry: No, that is not a sufficient reassurance. We would like to press the amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 12.

Division No. 27]

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

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

12.30 pm

Liz Kendall: I beg to move amendment 208, in clause 22, page 30, line 36, at end insert—
‘140A Duty to publish information
A commissioning consortium must make arrangements to publish information about services that it is seeking to commission in such a manner that ensures that any prospective providers are able to respond to express an interest in providing the services, before commissioning decisions are taken.’.

The amendment deals with the issue raised by the hon. Member for Southport and by my right hon. Friend the Member for Rother Valley, and the issue that I referred to earlier, which was highlighted by the Select Committee on Health, about managing conflicts of interest, particularly where GPs could be commissioning other primary and community services. I am sure that many hon. Members here have spoken to local pharmacists, as well as national organisations, who are all understandably concerned that GPs may end up commissioning services that are currently provided by pharmacies, or even that GPs may take over and start running such services—understandably so, perhaps, because GPs would be able to attract more patients and bring more money into the consortium. I want to give some specific examples that will help bring the issue to life.

As hon. Members know, pharmacies provide fantastic services such as smoking cessation, diabetes testing—diabetes, as we know, is a growing problem—and particularly in London, as well as across the country, chlamydia screening services. Boots pharmacy has done fantastic work on that issue, helping hundreds of young
women to access tests and screenings. Not everybody wants to talk to their GP about such issues, so the work done by pharmacies there is outstanding.

In our constituencies, many of us find pharmacies easier and more convenient, and that particularly applies to disadvantaged groups, such as the homeless, or those whose problems mean that they are much more comfortable visiting a pharmacy. The concern is whether we can ensure that such services continue to be effectively commissioned, not necessarily by pharmacists, but by whoever is in the best place to provide the easiest access to the widest group of people. That is particularly true in disadvantaged communities, such as the one I represent.

The purpose of the amendment is to require consortia to publish information about the services that they seek to commission in such a manner that ensures that any prospective provider—whether it is the NHS, the voluntary sector, or the private sector—is able to respond to express an interest in providing the services before commissioning decisions are taken. Because consortia have GPs as members, it is vital that we have a series of checks and balances in place to ensure that conflicts of interest are managed.

In previous debates, the Minister has said that such conflicts of interest will be set out in the constitution. What this amendment—and others that I shall come to later—seeks to do is to make it clear that in every part of the process, consortia cannot simply commission services without going through the proper process. It is expected that compliance with the amendment’s requirements would be achieved by issuing some kind of formal tender or notice for any service that is being commissioned, so that the best possible service is provided, whether it is from the NHS, voluntary or other providers, as I have said. Placing that requirement on a consortium is one way in which checks and balances could be put in place to avoid conflicts of interest.

Mr Burns: In moving the amendment, the hon. Lady has flagged up an important issue. As she knows, we will be dealing with the core issue of conflicts of interest on amendments 211 and 217, so, for the purposes of this debate, I will stick strictly to the specific purpose of the amendment. I hope the hon. Lady will accept that as the right way forward.

I believe that amendment 208 is unnecessary. Where services are to be commissioned, commissioners need to ensure that such services are specified and advertised in a way that does not give an unfair advantage to any particular provider. From the time commissioning consortia are established, they will have a responsibility under procurement law to act in a fair, transparent and non-discriminatory way when commissioning services from the full range of potential providers. When services are commissioned, commissioners need to ensure that those services are specified and advertised in a way that does not give an unfair advantage to any particular provider. For those reasons, I would encourage the hon. Lady to withdraw her amendment. I believe that the existing situation is adequately covered.

Liz Kendall: I thank the Minister for his response. It is right that good practice procurement guidelines outline that. We will come on to the substance of trying to prevent conflicts of interest in amendments 211 and 217. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 209, in clause 22, page 31, line 44, at end insert—

‘14QA Arrangements in respect of local authorities

A commissioning consortium must work closely with local authorities in the provision of services for people with complex health and/or social care needs, carers or those otherwise at risk of poor health or care outcomes or social exclusion.’

The Chair: With this it will be convenient to discuss the following: amendment 210, in clause 22, page 34, line 12, leave out from ‘consortium’ to end of line 16 and insert

‘is required to address the needs identified in the most recent joint health and wellbeing strategy published by the Health and Wellbeing Board by virtue of section 180 of the Health and Social Care Act 2011 and must consult each relevant Health and Wellbeing Board about its view on whether the plan adequately addresses the needs of its locality.’

Amendment 145, in clause 22, page 34, line 21, at end insert—

‘(aa) a Health and Wellbeing Board must have regard to the views of a relevant overview and scrutiny committee for its area (where operated) when preparing to give its opinion on consortia commissioning plans.’

Amendment 146, in clause 22, page 34, line 23, after ‘opinion’, insert ‘and the views of any overview and scrutiny committee.’

Amendment 212, in clause 22, page 34, line 26, at end insert—

‘(SA) Where the Board has received the opinion of the Health and Wellbeing Board it must reply to that opinion in 28 days.’

[Peter Bone in the Chair]

Amendment 211, in clause 22, page 34, line 33, leave out ‘28 days’ and insert ‘the timescale for preparing the overview and scrutiny committee’s report.’

Amendment 144, in clause 22, page 34, line 21, leave out ‘and’ and insert—

‘14QB Any relevant Health and Wellbeing Board must consult each relevant Health and Wellbeing Board about its view on whether the plan adequately addresses the needs of its locality.’

Amendment 143, in clause 22, page 34, line 24, leave out ‘a Health and Wellbeing Board’ and insert ‘the health and wellbeing boards in respect of the local area (where operated) in which it is responsible.’
Emily Thornberry: These amendments again touch on important issues, and the Minister will recognise that some of them have been proposed by the Centre for Public Scrutiny, among other sources.

Amendment 209 concerns a consortium’s arrangements in respect of local authorities. This part of the Bill places an obligation on the NHS commissioning board to encourage commissioning consortia to work closely with local authorities for the provision of services, which is to be applauded. However, the duty to work closely with local authorities in the provision of services also needs to be put directly on consortia. It is not enough to expect pressure to be exerted on them by faceless people in Whitehall. It is important for GPs themselves to know that they have an obligation to work with local authorities, particularly in relation to complex health and social care needs.

I think all parties can agree that we must integrate services, particularly health and social care, more than at present. However, it is not sufficient simply to talk about it. When opportunities are available, as in the Bill, to tie new bodies, such as commissioning consortia, to an obligation to work closely with local authorities in the commissioning of care, that is important, particularly when commissioning consortia replace primary care trusts, many of which have developed integrated working. I know that in my primary care trust, for example, there would be a person at one desk employed by the PCT—and, therefore, by the NHS—sitting next to somebody working for the local authority, who is providing social care. Neither of them knows who their boss is, or who is paying their salary, but they both know that they have an obligation to ensure that the needs of the local population are met.

That is the sort of integrated care and integrated services to which we should aspire. If we are going to throw that out, we need to ensure that what replaces it works properly. One of the greatest concerns is that the fractured service we will have from GP consortia will mean that they will not work sufficiently closely with local authorities, and perhaps not even meet current standards, let alone improve on them. The amendment therefore include a duty in the Bill for GP consortia to work closely with local authorities.

Although amendment 210 is important, having thought about it overnight, it is my view, particularly having listened to the Secretary of State for Health, that it does not go far enough. I am confident that the Government will be looking further at what more they can do. I look at the transcript of what the Secretary of State will be looking at. I am confident that the Government will be looking further into what more they can do. I do not go far enough. I am confident that the Government will be looking further into what more they can do. I am confident that the Government will be looking further into what more they can do. I am confident that the Government will be looking further into what more they can do. It is not in the interests of the people of England and Wales. The health and well-being boards of local authorities are going to have sign-off of commissioning plans of GP consortia, that is a definite improvement. It is not in the Bill at the moment, but if the Government are about to introduce that in an amendment, then good. They will find friends on the Opposition Benches, because that is the sort of power that matches the hyperbole that comes sometimes from the Government Front Bench. We look forward to that on Report, because at the moment we do not have it.

Amendments 145 and 146 seek to bring in the views of the relevant overview and scrutiny committee when the health and well-being board is considering consortia commissioning plans. Since we have overview and scrutiny bodies, we should use them. Amendment 212 states that, where the board has received the opinion of the health and well-being board, it must reply to it in 28 days. That highlights just how poor the relationship is, and the power that the health and well-being board has in relation to commissioning consortia at the moment. The amendment stipulates that the board reply to any views expressed by the health and well-being board within 28 days. I suspect that at the moment the Minister will be against that, but I am sure that, when he reviews the powers of health and well-being boards and ensures that they have sign-off of commissioning plans, we will have something much stronger even than that. At the moment, this is a probing amendment and is unlikely to be put to a vote, but we want to hear Government’s current thinking, because we expect it to change in the near future.

Mr Burns: Amendment 209 revisits the issue of achieving greater collaboration between consortia and local authorities for the purposes of joining up health and social care provision. Hon. Members will recall that the Committee discussed that when it considered amendments to clause 4. I need not remind hon. Members that the Government recognise the importance of integration between health and social care. As I have previously set out at length in earlier debates on this point, the Bill includes strengthened proposals in relation to collaboration and integration between health and social care commissioners. The amendment is unnecessary, as I shall demonstrate, and I will hopefully reassure the hon. Member for Islington South and Finsbury. The NHS commissioning board will have a duty in new section 13J of the 2006 Act to exercise its functions to encourage consortia to work closely with local authorities in arranging for the provision of services and the use of section 75 arrangements in particular.

12.45 pm

The board has levers that it can use to influence consortia behaviour, such as the publication of commissioning guidance and the commissioning of outcome framework indicators against which consortia performance will be assessed. The hon. Lady said that consortia need an obligation to work with local authorities. I hope that I can reassure her, because they do. Consortia have a duty under section 82 of the 2006 Act to co-operate with local authorities to secure and advance the health and welfare of the people of England and Wales. The forum for bringing together health and social care commissioners is the health and well-being board. Clause 179 places a duty on health and well-being boards to encourage integrated working.

Clause 177 requires health and well-being boards to consider the use of commissioning flexibilities, such as pooled budgets or lead commissioning in developing the joint health and well-being strategy. Health and well-being boards can bring that duty to bear when assessing whether the approaches set out in consortia
commissioning plans take proper account of the joint health and well-being strategies. I hope therefore that the interest of Opposition Members has been satisfied on this point, and that the amendment will be withdrawn.

Amendment 210 would require GP consortia to address in their commissioning plans the needs identified in their local health and well-being strategy, and to consult each relevant health and well-being board about its view on whether the commissioning plan adequately addresses local needs. I understand the intention behind the amendment. It would help to ensure that commissioning consortia develop their commissioning plans within the framework of the joint health and well-being strategy, which is itself a high-level strategy for how to make GPs identify with the joint strategic needs assessments.

We agree with the sentiment of the amendment, which is why we have made provision for it under clause 177. It might help if I outline the purpose of that clause. It requires local authorities, consortia and the commissioning board to have regard to JSNAs and the joint health and well-being strategies when discharging particular functions. In partnership with the reform to the provision on JSNAs under clause 176, the clause establishes a framework for commissioners, patient representatives and local councillors across health and social care to think strategically about how the needs of the people they serve can be met. It places a duty on commissioners to have regard to such strategy when they commission services.

The amendment would to some extent duplicate the duties under clause 177 and is therefore unnecessary. Adding an additional requirement that the consortia commissioning plan should align closely to the joint health and well-being strategy would simply serve to make it a duplicate of that plan. Moreover, the amendment would have the unintended consequence of requiring commissioning consortia to act in certain ways that would limit their autonomy. That would undermine the progress on allowing clinicians to make decisions in the interests of their patients, albeit in the framework given by the joint health and well-being strategy. It goes much further than the majority of the responses to the consultation, which were generally content that the wording on consortia “having regard” to the joint strategic needs assessment and the joint health and well-being strategy was sufficient to ensure that they properly addressed the identified need.

Amendment 145 would give the health and well-being board a new duty to have regard to the views of the local authority overview and scrutiny committees when providing a view on whether GP consortia commissioning plans in their area have had regard to the joint health and well-being strategy. Amendment 146 would require consortia to include a statement of the opinion of any overview and scrutiny committee in their commissioning plan. That would go further than the current requirement for the GP consortia commissioning plan to include the opinion of relevant health and well-being boards on whether the plan takes proper account of the most recent joint health and well-being strategies. It would require health and well-being boards in reaching their view to have regard to the views of the local authority overview and scrutiny committee. We recognise the valuable role that scrutiny has to play in providing transparency, accountability and local challenge, which is why we listened and responded to the consultation responses, giving local authorities flexibility on how they discharge the scrutiny function, while retaining the separation between executive and scrutiny functions by preventing delegation to the health and well-being board.

The amendment would blur the separation between executive and scrutiny functions that we have recognised is so important. As the County Councils Network said when we proposed in the White Paper that scrutiny functions should be placed on the health and well-being boards, “it is not appropriate for Health and Wellbeing boards to have both the executive and scrutiny functions as they cannot effectively scrutinise their own decisions”.

To require health and well-being boards to have regard to the views of the overview and scrutiny committee would interfere with a health and well-being board’s ability to give its own independent opinion. The lines will be blurred, and the separation of the health and well-being board and the scrutiny function could be compromised. Local authorities will continue to have scrutiny functions separate from the health and well-being board, and they will be able to scrutinise matters concerning certain members of the board.

Emily Thornberry: If I understand the Minister correctly, he is asserting that it would be wrong for health and well-being boards to pay any attention to what overview and scrutiny said, because that would muddy the waters. What is the purpose of overview and scrutiny if health and well-being boards do not pay any attention to what it says?

Mr Burns: No, I am not saying that at all. I am saying I do not think it is sensible to formalise a requirement that health and well-being boards must have regard to the views of the overview and scrutiny committee, because I believe that that could interfere with the ability of the health and well-being board to give its independent opinion.

As I was saying, the functions and powers that I have outlined will maintain the separation between executive and scrutiny functions that people have asked for, retaining local authorities’ ability to play a leading role by influencing commissioning through health and well-being boards, as well as scrutinising local health services through their scrutiny functions. I believe that that separation is appropriate. It is what people have asked for following the consultation process—including experts such as the Centre for Public Scrutiny. It is for those reasons that I urge the Committee to reject amendments 145 and 146.

Amendment 212 would require the commissioning board to respond to the health and well-being board within 28 days if it had written to express its opinion on whether the commissioning consortia plan had taken proper account of the joint health and well-being strategy. We appreciate that the commissioning board has a role to play if commissioning consortia are not meeting their legal duties. As I have explained, the health and wellbeing boards have the power to write to the commissioning board with their opinion on whether they feel consortia commissioning plans have taken proper account of the joint health and well-being strategy. That is in addition to duties on consortia to have regard to the strategy and the JSNA.
However, we hope that that power will rarely be needed if health and well-being boards are working well. Consortia will be fully involved members of the health and well-being board, contributing to the joint development of the joint strategic needs assessment and the joint health and well-being strategy, alongside elected representatives and other local commissioners. We fully expect consensual partnership working to flourish in future as a result of the common flexible framework we have outlined in later clauses. We want to support the changes in culture and behaviours that are needed to bring about effective partnership working, which will result in improved health and well-being for local people.

The amendment does not take into account the provision in the new section 14Z2 that clause 22 would insert into the 2006 Act. If consortia are not fulfilling their legal duties—for example by not having due regard to the joint health and well-being strategy—there are grounds for the commissioning board to initiate its intervention powers. The new section grants the NHS commissioning board a power to seek further information and/or explanation from a consortium if it has reason to believe that, as a result of a letter from a health and well-being board, for example, the consortium might fail, is failing or has failed to discharge its functions properly. If the board, having sought additional information, is satisfied that the consortium has failed, is failing or is at significant risk of failing, it can exercise the intervention powers conferred by new section 14Z6. The amendment would work against the development of effective partnerships, place a burden on the NHS commissioning board to respond to all letters from health and well-being boards and duplicate some existing provisions in the Bill. It is for those reasons that I would urge the Committee to reject the amendment.

**Emily Thornberry:** I beg to ask leave to withdraw the amendment, but I give the Government notice that we will revisit it.

*Amendment, by leave, withdrawn.*

**Mr Burns:** I beg to move amendment 94, in clause 22, page 32, line 20, after ‘grant’, insert ‘or loan’.

The amendment would allow consortia to give loans, as well as grants, to voluntary organisations that provide or arrange for the provision of similar services. Consortia may use such organisations to support the discharge of their functions. For example, a consortium may want a voluntary organisation with particular expertise in certain care pathways or conditions, such as diabetes, to commission services on its behalf. Such partnerships can foster innovation, and consortia should have the means to encourage them. It may be the case that a loan or grant is necessary for the voluntary organisation to grow the capacity to undertake the task.

**Liz Kendall:** Will the Minister confirm that such grants can be made to voluntary organisations to commission and to provide services? Would that also include private sector companies? Why are voluntary organisations specified?

**Mr Burns:** The reason we specify the voluntary sector is that the grants and loans cannot be for the private sector, as the hon. Lady would expect.

**Mr Steve Brine (Winchester) (Con):** My point follows the logic and consequences of that provision. I like this line of the Bill, and the amendment is needed. In my constituency, the Winchester branch of the National Childbirth Trust runs a voluntary organisation called BABIES—it is a long acronym and I will not go into it—which is a breastfeeding support group that provides superb essential support to families in my constituency. The Minister will know that the Department of Health has made clear its support and the public health benefits of breastfeeding, so might a service such as BABIES look to commissioning consortia for help?

**Mr Burns:** In answering the interventions of the hon. Lady and my hon. Friend, I will put them in the following context. We are basically giving consortia the powers that are currently conferred on PCTs under section 64 of the Health Services and Public Health Act 1968, which allows for PCTs to give both grants and loans to relevant voluntary organisations. Such voluntary organisations have a particular expertise in certain areas of care pathways or conditions, and the grants or loans are to help them to grow the necessary capacity to provide care or help to patients. Consortia would be able to make both grants and loans subject to any terms and conditions that they consider appropriate. I hope that the Committee will agree to the amendment.

**Liz Kendall:** The Government’s amendment is not clear. If the consortium wants to commission a service from the voluntary sector, such as that described by the hon. Member for Winchester, why could that not be done through a normal commissioning procedure?

1pm

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

*Adjourned till this day at Four o’clock.*