Public Bill Committee

HEALTH AND SOCIAL CARE BILL

Fifteenth Sitting
Thursday 10 March 2011
(Morning)

CONTENTS

Written evidence reported to the House.
Clause 50, as amended, agreed to.
Clauses 186 to 191 agreed to.
Clauses 192, 166 and 167, as amended, agreed to.
Schedule 13, as amended, under consideration when the Committee adjourned till this day at One 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.

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Monday 14 March 2011

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The Committee consisted of the following Members:

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

† Abrahams, Debbie (*Oldham East and Saddleworth*) (Lab)
† Barron, Mr Kevin (*Rother Valley*) (Lab)
† Blenkinsop, Tom (*Middlesbrough South and East Cleveland*) (Lab)
† Brine, Mr Steve (*Winchester*) (Con)
† Burns, Mr Simon (*Minister of State, Department of Health*)
† Burstow, Paul (*Minister of State, Department of Health*)
† Byles, Dan (*North Warwickshire*) (Con)
† Crabb, Stephen (*Preseli Pembrokeshire*) (Con)
† de Bois, Nick (*Enfield North*) (Con)
† James, Margot (*Stourbridge*) (Con)
† Kendall, Liz (*Leicester West*) (Lab)
† Lefroy, Jeremy (*Stafford*) (Con)
† Morgan, Nicky (*Loughborough*) (Con)

† Morris, Grahame M. (*Easington*) (Lab)
† Poulter, Dr Daniel (*Central Suffolk and North Ipswich*) (Con)
† Pugh, John (*Southport*) (LD)
Shannon, Jim (*Strangford*) (DUP)
† Soubry, Anna (*Broxtowe*) (Con)
† Sturdy, Julian (*York Outer*) (Con)
† Thornberry, Emily (*Islington South and Finsbury*) (Lab)
† Turner, Karl (*Kingston upon Hull East*) (Lab)
† Twigg, Derek (*Halton*) (Lab)
† Wilson, Phil (*Sedgefield*) (Lab)

Chris Stanton, Mark Etherton, *Committee Clerks*

† attended the Committee
Public Bill Committee

Thursday 10 March 2011

(Morning)

[MR MIKE HANCOCK in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 87 Baj Mathur
HS 88 Fiona Day
HS 89 Fiona Duxbury
HS 90 PharmaTrust UK Limited
HS 91 British Society for Rheumatology

Clause 50

CO-OPERATION WITH BODIES EXERCISING FUNCTIONS IN RELATION TO PUBLIC HEALTH

9 am

The Minister of State, Department of Health (Paul Burstow): I beg to move amendment 344, in clause 50, page 62, line 20, at end insert—

‘( ) In section 271 of that Act (territorial limit of exercise of functions), in subsection (3) after paragraph (d) insert—

“(da) section 247A (co-operation in relation to public health functions),’.”

This minor and technical amendment will ensure that clause 50 functions as intended. New section 247A of the National Health Service Act 2006, which the clause inserts, will require co-operation between the Secretary of State and other people or organisations engaged in health protection activity, to ensure a joined-up approach to fighting the spread of disease and other dangers to health. Most provisions in the Bill extend to England and Wales only, but apply only to England. However, by virtue of clause 280(3), the intention is that clause 50 will apply across the UK, including the areas covered by the Governments of the devolved Administrations.

It is important that the Secretary of State can co-operate with the relevant authorities in other countries to protect the UK and international health. The amendment is necessary to ensure that the Secretary of State is able to provide assistance outside England under his duty of co-operation. Section 271(1) of the 2006 Act states that the functions of the Secretary of State “are exercisable only in relation to England.”

The amendment will disapply the section and allow the Secretary of State to provide assistance outside England under his duty of co-operation, for example, by assisting developing countries to develop strategies for fighting disease.

Amendment 344 agreed to.

Clause 50, as amended, ordered to stand part of the Bill.

Clauses 186 to 191 ordered to stand part of the Bill.

Clause 192

LISTS OF PERFORMERS OF PHARMACEUTICAL SERVICES AND ASSISTANTS ETC.

Paul Burstow: I beg to move amendment 345, in clause 192, page 163, line 3, leave out ‘by virtue of’ and insert ‘under’.

The Chair: With this it will be convenient to discuss Government amendments 346 and 347.

Paul Burstow: These amendments to section 276 and schedule 17 of the 2006 Act are consequential provisions in clause 192. The clause replaces sections 146, 149 and 150 of the 2006 Act with two new sections that enable the NHS commissioning board to make regulations that make provision for the preparation, maintenance and publication of lists of performers of pharmaceutical services.

Amendment 345 makes a minor alteration to the wording of new section 147B so that it reads “under” rather than “by virtue of”. Amendment 346 removes from the index of defined expressions in section 276 the words “supplementary list”, as that definition is no longer necessary. Amendment 347 amends paragraph 13(1)(b) of schedule 17 to the 2006 Act to ensure that the provision will contain the correct reference to new section 147A, instead of section 146, which is being repealed.

Amendment 345 agreed to.

Amendments made: 346, in clause 192, page 163, line 28, at end insert—

‘( ) In section 276 of that Act (index of defined expressions), omit the entry for “supplementary list”.’.

Amendment 347, in clause 192, page 163, line 28, at end insert—

‘( ) In Schedule 17 to that Act (exempt information relating to health services), in paragraph 13(1)(b), for “146” substitute “147A”.’—(Paul Burstow.)

Clause 192, as amended, ordered to stand part of the Bill.

Clause 166

HEALTHWATCH ENGLAND

Paul Burstow: I beg to move amendment 415, in clause 166, page 139, line 2, after ‘with’ insert ‘information and’.

The Chair: With this it will be convenient to discuss amendment 348, in clause 166, page 139, line 2, at end insert

‘and the Commission shall respond in writing to the committee about its response or proposed response to the advice’.

Paul Burstow: I will speak primarily to the Government amendment—the lead amendment. It is perhaps worth saying at the outset that I am aware that some people argue that HealthWatch England should be a separate organisation from the Care Quality Commission, or should have a greater degree of independence from its workings. I certainly understand their concerns. I also
understand the strength of feeling behind ensuring that the patient voice is heard throughout the health and care system. However, let me explain why I believe that having HealthWatch England as a committee, as part of the Care Quality Commission, is the right choice and very much in the interests of patients and service users.

As hon. Members will know, our vision for the NHS is built around the patient. It includes bringing commissioning decisions closer to patients through the establishment of commissioning consortia. It also includes the provision of far more information about the quality of services through the information revolution, on which we published a consultation last year; we will publish our reply to the many responses we received to that consultation in due course. However, the new NHS will not deliver on that ambition if we do not make sure that patients have a stronger voice in the system. We have considered how best that can be achieved and how the patient voice can be amplified through the new NHS commissioning architecture. As part of the CQC, HealthWatch England will have a real influence. It will work in partnership with the commission, with the clear ability to escalate local concerns.

As the National Institute for Health and Clinical Excellence said in response to our White Paper consultation, “The connection between local HealthWatch and HealthWatch England, based in the Care Quality Commission, should greatly increase the likelihood that public and patient concerns about the quality and safety of local NHS services will be heard and acted upon.”

Liz Kendall (Leicester West) (Lab): The Patients Association, which speaks on behalf of many patients in the country, unlike NICE, says:

“We are concerned that HealthWatch England will sit within the CQC. How will the public be convinced of the independence of HealthWatch England when it sits within the regulator?”

Indeed, the Government’s own impact assessment says:

“Setting up HealthWatch as a statutory committee of the CQC [means] it would not be formally independent of the NHS commissioning architecture. As part of the CQC, HealthWatch England will have a real influence. It will work in partnership with the commission, with the clear ability to escalate local concerns.

Liz Kendall: Will the Minister give way?

Paul Burstow: The hon. Lady almost predicts the remainder of my speech, which will attempt to allay the concerns that the Patients Association and she, on its behalf, have expressed. To be honest, we do not feel that it would be in the best interests of patients to set up a stand-alone body, which would not have adequate resources to be able to deliver for patients. As a committee of the CQC, HealthWatch England will be able to take full advantage of its infrastructure and expertise: for example, it will be able to draw upon the CQC’s extensive information networks and analytic ability. Returning to the consultation responses, a member of the public said that the role within the CQC will give HealthWatch “substantially more weight”.

The next point is important because it starts to address directly the concerns of the Patients Association, for which organisation we have great respect. We wanted to ensure that HealthWatch England had a distinct identity within the CQC. That is why it will be a statutory committee, represented on the CQC’s board by its chair, who will be appointed by the Secretary of State. The Bill sets out clearly the committee’s powers to provide advice to the NHS commissioning board, the Secretary of State, the CQC and Monitor.

Opposition amendment 348 would require the CQC to respond in writing to advice and information that it receives from HealthWatch England committee. I sympathise with the point the Opposition are trying to make on behalf the Patients Association, with the intention of ensuring that HealthWatch England is able to have its own distinct identity within the CQC. However, the amendment could work against the building of effective working relationships between HealthWatch England and the CQC. Staff working for the committee and the wider commission should be having an open and ongoing dialogue about their work. Formalising that as the amendment proposes would give the impression that communication between the committee, with its independent role, and the CQC should be conducted by means of correspondence rather than open and ongoing dialogue. For that reason, we do not support that approach to prescribing the nature of that relationship.

Government amendment 415 is simply intended to correct a minor drafting error with regard to the terms “information” and “advice”. New section 45A of the Health and Social Care Act 2008, inserted by the clause, deals specifically with the functions to be exercised by HealthWatch England. Under new section 45A(3) HealthWatch is to provide the Secretary of State, the NHS commissioning board, Monitor and English local authorities with information and advice on the views of people who use health and social care services and other members of the public on their needs for and experiences of health and social care services. Similarly, HealthWatch England is to provide information and advice on the views of local healthwatch and other persons, on the standard of provision of health and social care services, and on whether or how the standard could or should be improved.

Paul Burstow: The important thing is that Healthwatch England has the ability to give that advice. If the advice is not followed, that would be made obvious by the fact that it is not followed. Where the Bill requires a communication that expresses and seeks to provide advice to the Secretary of State, the NHS commissioning board or others, it would, of course, require such a conversation.

Derek Twigg: With respect, the Government have made a great deal of how they are improving scrutiny, local accountability and general accountability for the national health service, so Healthwatch England is a...
very important body. If the Secretary of State rejects the advice of such an august body, given the Government’s wish for transparency, accountability and greater scrutiny, should not the reasons for the rejection be published?

**Paul Burstow:** The hon. Gentleman is absolutely right, and we agree that HealthWatch England and local healthwatch are an important part of the new architecture and an important way in which the patient voice is heard. I draw attention to proposed new section 45A of the 2008 Act, which addresses the advice given by HealthWatch England. Subsection (5) states:

“A person provided with advice under subsection (3) must inform the Healthwatch England committee in writing of its response or proposed response to the advice.”

That would apply to the Secretary of State. It is there in black and white on the face of the Bill, which is a novelty in legislation. Hopefully the hon. Gentleman will welcome the fact that we do not leave the matter to regulations, as used to be done in the past. I hope that reassures him.

I conclude my remarks by saying that the amendment provides greater consistency by providing that HealthWatch England may provide the commission with both information and advice on such matters.

If I have not been able to persuade and reassure Opposition Members and they choose to press amendment 348, I urge my colleagues to oppose it.

**Emily Thornberry** (Islington South and Finsbury) (Lab): I am grateful to my hon. Friends for their assistance. We seem to have strayed into a clause stand part debate. I seek your guidance, Mr Hancock, on whether I ought to address the amendments or discuss the wider issues.

**The Chair:** I think we should stick to the amendments.

**Emily Thornberry:** Thank you. I will come back to the clause stand part debate in a moment.

Amendment 348 would place a duty on the commission to respond in writing to HealthWatch England with its response or proposed response to the advice. The reason for the amendment, as the Minister has already anticipated, is that there is spreading and deepening concern about the place of HealthWatch England in the CQC. We all agree that we should have a national healthwatch informed by local healthwatch bodies. That is greatly to be welcomed, but a structural problem is being created by the Bill in that HealthWatch England will have a place within the CQC.

The CQC is, of course, a regulator; it is supposed to conduct investigations. I have been thinking about what would happen if, for example, HealthWatch England was suddenly to tell CQC that 40 different hospitals or areas need urgently to be investigated. The CQC, as we all know, will not have an ideal amount of investment and will not be of an ideal size. The Minister frowns, but he knows that. The CQC needs to be much larger than it is to do its job effectively and make the number of visits it needs to make.

The concerns go together. There is a concern about the amount of money being spent to set up the CQC and the number of visits it will be able to make to old people’s homes, for example. On the other hand, HealthWatch England is supposed to be independent and it might need to suddenly tell the CQC that it has to do 40 different investigations for which it simply does not have the staff. They are sharing a building and HealthWatch England is part of the sub-committee of the CQC. One could imagine the good edges of HealthWatch England being knocked off by a close relationship with the CQC and by being dependent on the CQC for its funding, its place and everything else.

**Paul Burstow:** Will the hon. Lady confirm that the legislative basis for the CQC and in its current arrangements for dealing with essential standards of quality and safety were put in place during the last Parliament by the Labour Administration, and that all of the decisions on staffing levels and budgets were made by that Government?

**Emily Thornberry:** Yes. What I am saying to the Minister is that HealthWatch England should not be part of CQC—for the arguments already made—if it is to have a role that stands up, makes sense, and does everything that the Government claims it will. I am quite prepared to be straightforward with the hon. Gentleman on this issue: I want HealthWatch England to be a strong independent voice for patients nationally, and for local healthwatch organisations to be the same locally. My concern is that the legislation does not do this, and it is quite clear to any open-minded and fair-minded person looking at the Bill that there are fundamental flaws in the arrangement. That is why the amendment has been tabled.

It may seem somewhat clunky for CQC to have to write back to HealthWatch England, particularly if they are in the neighbouring office, but the point is that there is supposed to be some form of separation between the two bodies. The amendment simply puts some acknowledgement of that into the Bill. Otherwise we are setting up a body to fail, and that is the last thing that we want.

**Paul Burstow:** I take issue with some of the language used, for example, “spreading and deepening concern”—that is a very interesting flourish, but I do not think it is evidenced by the responses to the consultation on the White Paper last year. More than 6,000 organisations responded, and I quoted just a couple of the well respected organisations that expressed support for the Government’s approach. Of course we listened carefully to all of the respondents to the consultation, and indeed we made many changes. We are trying to make sure that the Bill does exactly what the hon. Lady says and exactly what we have intended all along. That is to have a clear, distinct and powerful voice for the patient and public interest, both at a national level—which does not currently exist—and at the local level.

**Emily Thornberry:** The difficulty the Minister gets into is that he tries to set up, with a flourish, bodies that most people agree with, but when we tell him that although the motivation and ambition are good, it is not being done in the right way, he does not listen. He says that there is no spreading and deepening concern. I hope he will be attending Liberal conference this weekend, where he will hear much concern expressed about precisely these sorts of bodies.

**The Chair:** We are all grateful for that plug for our conference.
Paul Burstow: I am sure that will increase the numbers attending and I am very grateful to the hon. Lady for the additional publicity, although I suspect that we will already have a very good crowd over the coming weekend, both inside and out. I look forward to taking part in many a debate about the very liberal nature of the reforms that we are introducing to the health service, which are very much about respecting organisations’ autonomy; devolving power in the system; ensuring that the patient’s voice is properly heard; and the fact that we trust clinicians to exercise their judgment.

Jeremy Lefroy (Stafford) (Con): I am sorry to interrupt the Minister in full flow. Does he feel that the arrangements, as proposed, would help to counter the problem we faced in Mid Staffordshire, where concerns raised all the way through—right up to the top and the office of the Secretary of State—were ignored or passed down because people said that they were not their responsibility? That is a concern of mine.

Paul Burstow: During the Committee’s proceedings, the hon. Gentleman has rightly articulated those concerns at all of the key points considered so far. As he knows of course, there is currently an independent inquiry taking place, and we are paying very close attention to those hearings. If we find that there are further matters to be addressed, we have every intention of making sure we pick them up.

I have already assured the hon. Member for Halton about the need for the Secretary of State to write back to HealthWatch England were it to express concerns, which is evidence for how this set of arrangements will be far more transparent. The very existence of HealthWatch England puts into the new architecture something that does not currently exist and, hence, an additional safeguard.

Derek Twigg: Let me pursue the point a little further, because I am not sure that the Minister answered my question fully. Writing to the Secretary of State and publishing the information are slightly different things. Will the responses from the various bodies given advice have to be published, or will they be obtainable under the Freedom of Information Act? Will the information be published for people to see, or will we have to ask for it?

Paul Burstow: Under the provisions, HealthWatch England will be able to publish the Secretary of State’s advice as part of its report. The intention is for the information to be available, and HealthWatch England will be able to publish it.

I want to return to something the hon. Member for Stafford, did not give a sufficient response.

Emily Thornberry: I have reminded the Minister before, and whether it will stand up as legislation. The legislation might have an impact on this country for much longer than the hon. Gentleman is in his current post. Whatever his motivation is does not really matter—what matters is that the legislation is good, rigorous and makes sense.

The Minister, in answer to questions from the hon. Member for Stafford, did not give a sufficient response. He should think more carefully about the hon. Gentleman’s question. Given what happened at the Mid Staffordshire hospital and that patients were not listened to, it is important to have a robust organisation—HealthWatch—led into by local healthwatch organisations. The hon. Gentleman’s question needs a better answer than, “Well, we have an inquiry going on. I am grateful for the question and we are setting up HealthWatch, which didn’t exist before.” That is not sufficient.

9.30 am

Paul Burstow: If that was all I had said, of course it would not be sufficient, which is why I also emphasised that the Bill establishes HealthWatch England as an independent committee of the CQC—a body that did not exist when the terrible incidents occurred at Stafford under the last Government’s watch.

Emily Thornberry: The Minister has underlined what I have just said. It is not sufficient for him to simply say that this is an independent committee of the CQC. In reality, it would be very difficult for it to be properly
independent, and as they begin to understand the legislation a large and increasing number of people and groups are saying that it is not sufficient. I implore the Minister to look at this again. If he is going to set up such an organisation, let us have a good one. Let us look at this again to ensure that it is properly independent and has a proper voice on behalf and for the sake of patients.

Amendment 415 agreed to.

The Chair: Emily, do you want to press amendment 348 to a vote?

Emily Thornberry: No. I have said what I wanted to with, I hope, sufficient clarify for the Government to listen to it.

Paul Burstow: I beg to move amendment 416, in clause 166, page 139, line 16, leave out ‘its functions during the year’ and insert ‘during the year the functions exercisable by it’.

The Chair: With this it will be convenient to discuss Government amendment 417.

Paul Burstow: Amendments 416 and 417 are minor and technical amendments relating to HealthWatch England. Amendment 416 corrects a minor inaccuracy in the drafting. Proposed new section 45B(1)(b) of the Health and Social Care Act 2008 provides that, as soon as possible after the end of the financial year, HealthWatch England must publish, I quote, “a report on the way in which it has exercised its functions”.

It is important to note that the functions set out in clause 166 are those of the Care Quality Commission. The commission must arrange for these functions to be carried out on its behalf by HealthWatch England. The amendment reflects this distinction and properly ensures that HealthWatch England has to report on the discharge of those functions by referring to its publishing a report on the way it has exercised, during the year, functions exercisable by it. In other words, the report of HealthWatch England will need to cover all the functions it is responsible for exercising on behalf of the Care Quality Commission under section 45A.

Amendment 417 ensures consistency in the provision governing the Secretary of State’s power to direct HealthWatch England if it is failing in relation to the discharge of functions. It also ensures that he or she can direct HealthWatch England where it is failing or has failed properly to discharge a function it is required to discharge, along with functions under section 45A. That brings the position in line with the power of direction under section 82, new subsection (1A)(a), which relates to the Secretary of State’s power of direction where HealthWatch England is failing or has failed to discharge those functions.

For the reasons I have set out, Mr Hancock, I hope that the Committee will feel able to support these amendments.

Amendment 416 agreed to.

Amendment made: 417, in clause 166, page 139, line 40, leave out ‘such function’ and insert ‘function it is required to discharge’.

Paul Burstow: I beg to move amendment 418, in clause 166, page 140, line 9, at end insert—

‘(c) Part 2 of Schedule 1 to the Public Records Act 1958,
(b) Part 2 of Schedule 1 to the House of Commons Disqualification Act 1975,
(c) Part 2 of Schedule 1 to the Northern Ireland Assembly Disqualification Act 1975.’

The Chair: With this it will be convenient to discuss Government amendments 419 to 422.

Paul Burstow: The amendments are, again, technical in nature, but they are important none the less. As hon. Members on both sides of the Committee know, transparency and accountability are the cornerstones of the Government’s health reforms, and the amendments further ensure that both are at the core of HealthWatch.

Amendments 419 and 420 ensure that the meetings of HealthWatch England and of local healthwatch organisations generally have to be held in public. Amendments 421 and 422 ensure that members of HealthWatch England and local healthwatch organisations are barred from being Members of the House of Commons and of the Northern Ireland Assembly. Members of local healthwatch organisations will be drawn from local communities, so it makes sense for local people to have an organisation that puts forward the local consumer voice about health and social care services. It would therefore be inappropriate for a Member of Parliament or a Member of the Northern Ireland Assembly to be a member of a local healthwatch organisation in England at the same time.

Emily Thornberry: I believe the Minister said that the meetings of HealthWatch England and of local healthwatch organisations would generally be held in public. In what circumstances would they not be?

Paul Burstow: We intend to apply the provisions of the Public Bodies (Admission to Meetings) Act 1960, which sets out in great detail the circumstances in which a body may exclude the press or public from its meetings. That generally applies when, for example, matters of commercial confidentiality are being discussed. In local authorities, it is a typical procedure which is used only as required, and that is not often. For the reasons that I have set out, I hope the Committee will support the amendment.

Amendment made: 419, in clause 166, page 140, line 9, at end insert—

‘(c) Where the Healthwatch England committee does not consist of or include all the members of the Care Quality Commission, the committee is nonetheless to be treated as doing so for the purposes of section 2(1) of the Public Bodies (Admission to Meetings) Act 1960.’

Question proposed, That the clause, as amended, stand part of the Bill.
Emily Thornberry: The amendments are technical, and although I was attempting to understand them at 11 pm last night, there were some that were beyond me, so I have been listening with care to the Minister. Much of what I wanted to say in relation to clause stand part has already been said, but I will outline our difficulties briefly.

Broadly, we welcome the establishment of HealthWatch England, which provides an opportunity for increasing patient engagement. We are pleased that there will be a national body representing the views of users of health and social care services—the public—and that there will be local healthwatches. HealthWatch England will advise the Secretary of State, the national commissioning board, Monitor, English local authorities and the CQC, which is to be welcomed. We understand the need for a national body such as this, but it is not an alternative to proper patient and public representation on key decision-making bodies, such as the board, consortia and so on, and there will be scrutiny of that, too. Having patients on HealthWatch England and having local healthwatch bodies is to be applauded, bit it is not sufficient in itself, and we need to ensure that there are checks and balances throughout the system.

Given HealthWatch England’s remit, it is a shame, first of all, that the name HealthWatch does not reflect its responsibility in relation to social care services. I am sure that the Minister shares my disappointment that social care is always the Cinderella service when it comes to health care, because some of the most important care that happens in this country is social care. If HealthWatch has a responsibility for not only looking after people’s health, but social care, we want to ensure that people have a clear signpost. Ensuring that it is called health-and-social-care watch is a small thing, but it would make a difference. As some of the most fractured service areas are in social care, some of the most important work that HealthWatch is likely to be doing nationally and locally will be to ensure that the most vulnerable are getting the care that they deserve, and that people know that they should go to health-and-social-care watch. That would be helpful. It is a small opportunity that would cost nothing. Again, it is a symptom of the problem that the Bill is going through. It is unfortunate that we have not had a chance to think through such issues. Had we had that chance, perhaps it would be entitled to pick up a certain piece of information locally?"?

Liz Kendall: The Government have made a great deal about the importance of giving patients and the public a much stronger and clearer voice within the NHS, a goal that I support. However, I do not believe that HealthWatch England as it is currently constituted will achieve that goal. I would like to make four points.

First, under the Government’s new architecture for the NHS in the Bill, there will be three big players—the national NHS commissioning board run by Sir David Nicholson; the Care Quality Commission, which will ensure that basic standards of care are met, run by Cynthia Bower; and Monitor, which will promote competition as a means of improving quality—or so the Government claim—run by David Bennett. However, there will not be a fourth, crucial arm, which is a much stronger voice for patients and the public. I do not agree with the Government’s approach. I firmly believe that if patients and the public are to have far greater say, equal to—arguably, it should be more important than—any of those three bodies, HealthWatch England should be an independent body.

Secondly, HealthWatch England will lack independence as it will sit within the CQC. There are two problems with that. Obviously, HealthWatch England would have to work closely with the CQC, as it would do with any of the other bodies, including the national commissioning board, because it would want to ensure that its information was passed up through into the CQC to allow it to conduct inspections and investigations. However, what if HealthWatch England thought that the CQC had failed to do its job or work as effectively as it should have? The hon. Member for Stafford will know that many players did not act as they should have over the problems with Mid Staffordshire. How would a committee that sat within the CQC be able to say, “You have failed to pick up a certain piece of information locally”?

Nick de Bois (Enfield North) (Con): I know that we are looking specifically at the clause, which deals with HealthWatch England. However, I do not think that we can look at it without including the power and influence of the local healthwatch, which is extremely important and feeds into the matter. But my main point is that HealthWatch England will have more influence if it has a seat at the table, backed up by its statutory role, to influence any Care Quality Commission issues. I want it to be at the table, and not another separate body that just makes another report. Let it be at the table to fight its cause. That is worth considering, without assuming that it will just lie down and be complacent.

Liz Kendall: I always listen carefully to what the hon. Gentleman says. If patients are truly to have an equal say in the service, I know—from experience in the NHS, which I know he also has—that it is the big organisations and big players that push the real decisions and have the real power. Yes, patients can have a seat at the table, but I firmly believe that they should have their own table.
The other problem related to HealthWatch England sitting in the Care Quality Commission is about resources, as my hon. Friend the Member for Islington South and Finsbury said. I take the Minister’s point that the plan for CQC was established under the previous Government and was absolutely the right approach, but let us be clear and honest. By the end of 2012 the CQC has to register 30,000 new providers, including 9,000 from primary medical services which have never been registered before and 12,500 new providers in social care. That is only the providers, but it also has to inspect and register individual sites. That is a huge task and the CQC, like other arm’s length bodies, is having its resources reduced. I urge hon. Members not to underestimate how massive that task is. The real concern is that sufficient resources might not be put into HealthWatch England. If the Minister wants to guarantee a ring-fenced budget for it, I would be grateful for his confirmation.

Paul Burstow: What I would like to do is to respond to the point made by the hon. Lady a few moments ago, which is worth putting on the record. She referred to the task of registering social care providers as if that is to be done in the future. I am sure that she would join me in applauding the CQC for successfully finishing that work on time and on budget.

Liz Kendall: I do, but the Minister will realise that new social care providers regularly come into the system. I was talking about the overall number of providers that the CQC will have registered—I am sorry if I was not entirely accurate in my comments. Those things change all the time and, under the Government policy of any willing provider, many more providers might come into the system. It is a big task and I urge hon. Members to be aware that HealthWatch England might not receive the resources that it needs for its vital role.

My third point is also about independence. It is not just that HealthWatch England will be sitting within the CQC; it is—I hope I have read this accurately—that the chair of HealthWatch England will be appointed by the Secretary of State. I am not sure how independent that person will be, and some members—

Nick de Bois rose—

Liz Kendall: Let me finish this important point. Some members of the committee of HealthWatch England will be elected—I assume that they will be from local healthwatches, but that is not clear—and others will be appointed. Questions have been raised with me and other members of the Committee about how independent those members will be.

Nick de Bois: I am grateful to the hon. Lady for picking up some sensitivity to that remark, because we should not necessarily be looking at the Bill from that end of the telescope. I am sure she would agree that the whole structure of the Bill will move democratic accountability a great step forward. It is not necessarily right to draw the conclusion that the Secretary of State therefore wants to micro-manage by default by making an appointment. That is clearly not the intention of the Bill.

[Liz Kendall] 

Liz Kendall: I am not saying that; I am saying that perhaps the chair of HealthWatch England might be appointed by the Appointments Commission, if Government Members were not abolishing it.

Dan Byles (North Warwickshire) (Con): I understand that the same levels of transparency and openness will apply to any such appointments. Surely the hon. Lady is not really arguing that there are open appointments if she believes that under the current structure of the CQC and so on, and others appointed under that open and transparent system are Labour party placemen and not entirely independent.

Liz Kendall: Alas, we are not in government anymore, so none of them are Labour party placemen. The hon. Gentleman may wish to look at the various reports about Sir David Nicholson’s appointment as head of the NHS commissioning board. As reported in the Health Service Journal, he was not the Secretary of State’s first choice. The Secretary of State wanted somebody else but the Minister for the Cabinet Office and others intervened to ensure that he did not get his first choice.

My fourth and final point relates to something that made me spring up earlier to intervene on the Minister, but alas, he did not take my intervention very early on. He had said that the Government do not believe that it would be “in the best interests of patients” to have an independent body—he referred to a body that is independent of the CQC, sitting separately from it. However, patients’ groups—not only the Patients Association but Rethink, Diabetes UK, the Stroke Association, the British Heart Foundation, National Voices, which represents 100 charities, Asthma UK, the Alzheimer’s Society, Breakthrough Breast Cancer and Age UK—have all questioned this. There is a gap between rhetoric and reality. The charities say: “The reforms will place £80 billion of the NHS budget into the hands of GPs, but plans to make GP consortia accountable to the public are far too weak.”

They go on to talk about the problems with local healthwatches, to which we will come. If the Minister genuinely believes that patients should have choice, control and a say over how services are run, surely he should listen to those organisations and give a far stronger role, not only to HealthWatch England, but to the local healthwatches.

Jeremy Lefroy: From the experience of Mid Staffordshire, I know that the key to patient involvement is the ability, first, of people to make a fuss when it needs to be made, and secondly, of the people in authority to listen and respond. At the moment we have neither of those things in practice. We have had weak local organisations. The LINk organisations—local involvement networks—were variable across the country, but in my part of the world the LINk was particularly weak, and we had an organisation higher up such that when letters were written right up to the Secretary of State’s office, the response was, “This is not really our business, because you’re dealing with a foundation trust.”

Emily Thornberry: I am listening with care to the hon. Gentleman. We should all learn from his experience. Does he share my regret that an assessment of the lessons to be learned from LINks was not made before
plans to establish local healthwatches were put into proposed legislation? Some LINks were successful and some were not. Perhaps it is important that we all learn why that was before attempting to establish an alternative.

Jeremy Lefroy: It is always important to learn, but whether and when one puts that learning into effect is up to local people. In Staffordshire, the LINks were closed and re-established under the organisation of the county council, and I believe that they are better now than they were before. However, I am certainly not arrogant enough to say that we cannot go on learning all the time.

Fundamentally, a mechanism by which people's voices are heard—not only heard but responded to—must be put in place by legislation. What is in the Bill is certainly an improvement on the current situation. I welcome the Minister's comment that he is following the Mid Staffordshire inquiry very carefully. If the need for such a mechanism were to emerge from that inquiry, and if one of the recommendations by Robert Francis were to be around that issue, I would urge the Government to look at that very carefully. In my experience, patients have simply been ignored—not throughout the country necessarily; it depends very much on the local organisations. In other primary care trusts, strategic health authorities and foundation trusts, there may have been extremely responsive people who got things sorted out, but we must ensure that that applies across the country and is not variable and dependent on the nature of the people who happen to occupy those positions.

Paul Burstow: I welcome the debate, which rightly puts the spotlight on an important part of the Bill. Whereas I think we share a common purpose in ensuring that the patient voice is clear, we clearly have disagreements about the method that is being employed. None the less, I hope that members of the Committee will accept, even if it is not necessarily a reassurance, that the intention is clear. We want to ensure that patient voice—nationally—is much strengthened compared to that which pertains today.

My hon. Friend the Member for Stafford brings a particular experience that rightly needs to be at the heart of the Committee's considerations. He is right to highlight some of the weaknesses in the current patient voice structures as being a cause—at least, a contributory cause—of what happened in Stafford. The Government set up the Francis inquiry specifically to ensure that we could learn lessons across the system. We had hoped that the inquiry would be in a position to conclude its work and report by now, but that has not proved possible. We do not deprecate that. It is simply the case that it is doing a thorough piece of work and we want it to have the time to do it.

I want to make it clear to my hon. Friend and reassure him that we will listen very closely during the inquiry's hearings and take its recommendations very seriously. If necessary, we will introduce amendments to deal with any points raised. It is important to put that on the record at this stage. We would not set up an inquiry without the intention of actually listening to what it recommends. I put that on the record.

Emily Thornberry: The Minister has anticipated my concern. If lessons are to be learned from the inquiry and the legislation can be amended to accommodate its recommendations, I am pleased to hear that the hon. Gentleman has an open mind and will amend the legislation if necessary.

Paul Burstow: That is absolutely the intention. I need to be straightforward with the Committee. Depending on the actual point at which the inquiry finishes and publishes, we may have to consider a second Bill in this Session, which I suspect the hon. Lady and I will spend much time on in due course, and which will also deal with health matters. The intention is clear and good.

Emily Thornberry: I make the obvious point that the Government are in charge of the timetabling of the Bill. It is open to the Government to slow down and listen to what people say so that we can accommodate the helpful suggestions that have been made from all sides.

Paul Burstow: Sometimes I think perhaps I should not have given way. The hon. Lady made a number of points to which I will try to respond. She made the point that HealthWatch England should not be inside the CQC. That is a running theme in contributions from Opposition Members. She argued that we have not considered the matter enough. One of the recurring arguments is that the pace is too quick.

I think we should quickly rehearse the timetable. We had a White Paper published in July last year. We had a full consultation with more than 6,000 responses. We deliberated on those responses and published a Command Paper in December, which set out how we responded to the consultation and how we saw that being reflected in subsequent legislation. We then published the Bill in January. We are now in Committee. That does not seem like an undue rush; it seems like a considered, deliberative process that ensures that Parliament is able to do its part of the job, which is to properly scrutinise the legislation in the fashion of the hon. Lady in her attempts both to improve and to undermine it.

10 am

Emily Thornberry: I do not know whether the Minister was listening to “The Food Programme” on Radio 4 when the Secretary of State—his boss—was asked about trans fats and he said that it was impossible for him to introduce legislation quickly enough because of the timetable. We all agree that trans fats should be banned because they are dangerous. The Secretary of State said he had to have an agreement with food producers because it was quicker to do that than to legislate. It struck me that if he can produce a health Bill such as this one—with all its complexity and clauses, completely turning upside down the NHS within a short period of time—he could certainly sort out trans fats.

The Chair: I do not think that intervention relates to clause stand part and I hope that Members will bear that in mind.

Paul Burstow: I shall take that as an instruction not to pick up that point and I will move straight on.

As I said, we want to have the maximum impact for patients, which means putting the measure at the heart, not on the sidelines, of the health care system; it would be on the sidelines if we did what Labour Members want us to do.
[Paul Burstow]

Why does HealthWatch England not fund local healthwatch? I have a clear recollection of the arrangements that were made when we last had a national body responsible for public and patient involvement. I had conversations at that time with the local organisations that were established under it, and I know that they felt very much at its beck and call. The relationship was not a healthy one. That influenced our decision to ensure that the commissioning of healthwatch at a local level should sit at the local level, to build on the existing strengths and relationships between local authorities and LINks and to ensure that we have a smooth transition to the new arrangements.

I should also like to pick up the point about funding. By having strong links into the local authority, local healthwatch organisations, as with LINks, will still be able to raise concerns about any commissioning or provision of social care. The hon. Member for Leicester West referred to the appointment by the Secretary of State of the chair of HealthWatch England. It is worth reminding the Committee that similar appointments apply to the big three, as the hon. Lady described them: the NHS commissioning board, Monitor and the CQC—and also, for that matter, NICE.

Monitor, the CQC and NICE were set up by the previous Government with those arrangements. It also worth pointing out that the appointments commission works only on behalf of the Secretary of State and as we remove that arrangement, all arrangements regarding public appointments will still be regulated by the Office of the Commissioner for Public Appointments. So the safeguards are there to ensure that this is not done in a partisan way, but that the best person for the job is appointed and able to discharge his or her duties in the public interest.

Can the funding of HealthWatch England be ring-fenced? Who would impose the ring fence and when does a ring fence turn into an artificial cap that limits the resources available to HealthWatch England? I am fearful that that could be the unintended consequence of such a ring-fencing and for that reason I do not support such a proposition. It is much better that the creative relationship that will operate between the CQC and HealthWatch England will provide access to all the analytical skills and other resources of the CQC.

I do not agree with the hon. Member for Leicester West when she describes the system architecture as having a big three. I am sure she will want to disabuse me of that in a moment, but let me develop my point. I do not agree that the NHS commissioning board, the CQC and Monitor are the only big three. She has missed out two important ingredients. I think patients’ voice is an important part of that and the architecture of the Bill ensures that it will be. Moreover, there is a change in the relationship between local government and the NHS: local government becomes part of the architecture as it has never been before.

Finally, if HealthWatch England thinks that the CQC is not fulfilling its statutory duties and functions, the Bill already provides for HealthWatch England to write to the Secretary of State to offer advice and information. I have already dealt with that in respect of her hon. Friend the Member for Islington South and Finsbury. It is in a unique place to be a critical friend when it comes to challenge around the performance of those tasks. There is a route by which concerns about the CQC can be directly raised with the Secretary of State, who has the necessary powers in extremis to deal with that. With those reassurances, I hope that Members will allow this clause to stand part of the Bill.

Question put and agreed to.
Clause 166, as amended, accordingly ordered to stand part of the Bill.

Clause 167

Establishment and constitution

Amendments made: 420, in clause 167, page 140, line 24, at end insert—

'( ) In the Schedule to the Public Bodies (Admission to Meetings) Act 1960, after paragraph (bj) insert—

(bk) Local healthwatch organisations;

Amendment 421, in clause 167, page 140, line 24, at end insert—

'( ) In Part 2 of Schedule 1 to the House of Commons Disqualification Act 1975, at the appropriate place insert—

Amendment 422, in clause 167, page 140, line 24, at end insert—

'( ) In Part 2 of Schedule 1 to the Northern Ireland Disqualification Act 1975, at the appropriate place insert—

(Paul Burstow.)

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

Emily Thornberry: The clause provides for the establishment of local healthwatch organisations. In general terms, it is welcomed. I thank the Minister—not this Minister, but the other one, the right hon. Member for Chelmsford—for the reassurance he gave the Committee that there will not be a hiatus between the end of LINks and the establishment of local healthwatch organisations. We do not oppose the clause, but there are concerns about the operation of local healthwatch organisations, which I will come to in the debate on schedule 13.

Question put and agreed to.
Clause 167, as amended, accordingly ordered to stand part of the Bill.

Schedule 13

Local healthwatch organisations

Paul Burstow: I beg to move amendment 423, page 312, line 22, leave out paragraph (b).

The Chair: With this it will be convenient to discuss Government amendment 424.

Paul Burstow: The amendments secure provision for auditing requirements for local healthwatch organisations which are appropriate for locally funded organisations. The National Audit Office brought the matter to our attention and supports our amendments to remove the Comptroller and Auditor General’s role in auditing local healthwatch organisations’ accounts.
The amendments will ensure that local healthwatch organisations are required to have their accounts audited. They enable the Secretary of State to direct local healthwatch organisations that their accounts must be audited in accordance with such requirements as are specified in the direction. When no direction is issued, local healthwatch organisations must arrange for their accounts to be audited in the manner that they consider appropriate.

We feel that those requirements accurately reflect the autonomy that local healthwatch organisations will enjoy to manage their own affairs and the flexibility that they will have to make appropriate local arrangements. With that, I hope that the amendments will be supported.

Amendment 423 agreed to.

Amendment made: 424, page 312, line 23 [Schedule 13], leave out sub-paragraph (4) and insert—

(4) The Secretary of State may direct an LHW that the accounts prepared by it under this paragraph are to be audited in accordance with such requirements as are specified in the direction; but subject to that, an LHW must arrange for the accounts so prepared to be audited in such manner as it considers appropriate.—[Paul Burstow.]

Emily Thornberry: I beg to move amendment 357, page 312, line 32, at end add—

3 Procedures

8 (1) An LHW shall adopt and publish procedures for making decisions about the exercise of its functions and shall review such procedures from time to time to ensure they remain effective and efficient for the purposes of carrying out LHW functions.

(2) An LHW shall adopt and publish procedures for selecting and authorising “authorised persons” to exercise LHW “rights of entry”, such procedures to have regard to safety, privacy and dignity of patients and service-users, the public, employees of health and social care commissioners and providers and LHW “authorised persons” and the LHW shall review such procedures from time to time to ensure they remain effective and efficient for the purposes of exercising LHW “rights of entry”.

(3) Procedures under subsection (2) shall specify the procedure to be followed by the LHW in determining the circumstances in which it intends to exercise “rights of entry” and the LHW shall make arrangements to bring the procedure to the attention of commissioners and providers of healthcare and social care services.

(4) An LHW shall meet in public, shall publish papers to be considered in advance of meetings and shall publish records of decisions taken.

(5) An LHW shall publish annual reports on how it has carried out its functions during the preceding 12 months, including its assessment of how effectively and efficiently it has carried out each of its functions over the period and the changes that have resulted to healthcare and social care services resulting from the exercise of its functions.

The schedule is the bones of the local healthwatch organisations—and that, unfortunately, does not say a lot. It is one of the schedules that the Minister, the right hon. Member for Chelmsford, said that he used to see when we were in government and that he used to complain about, but I am sure that that is not right. It is difficult, when looking at this schedule, to understand properly what local healthwatch organisations will be like. It essentially gives provision for the Government to introduce, at some future stage, a whole lot of regulations. Earlier this morning, there was talk about the great benefit of putting things into the Bill as opposed to there being regulations at a later stage. This amendment attempts to help with that.

There is a sub-clause to proposed new schedule 16A, “Procedures” (8), to allow local healthwatch organisations to adopt and publish procedures for making decisions about the exercise of their functions—in other words, to have a constitution that everyone knows about—and to review such procedures from time to time, to ensure that they remain effective and efficient for the purposes of carrying out their functions. The healthwatch organisations shall publish and adopt procedures for selecting authorised persons to exercise the local healthwatch rights of entry.

One of the great powers that the local healthwatch organisations will have is the power to insist on going into local provision—for example, turning up at an old people’s home and saying, “We want to come in; we hear terrible stories about this place”. But it needs to be done in a way that has regard to the safety, privacy and dignity of patients and service users.

It is also important to find out who should be allowed in and who is not going to be allowed in and in what circumstances. Those procedures need to be published by the local healthwatch so that it is in some way accountable to the local community that it is seeking to serve. Again, local healthwatch will review such procedures from time to time to ensure that they work.

The amendment’s new subsection (2) relates to the procedure to be followed by the local healthwatch in determining the circumstances in which it intends to exercise rights of entry. When will it enter local provision and when will it not? There should be some form of accountability to the local public, and local healthwatch should meet in public. Papers should be published in advance so that people know what they are going to be discussing and they can be involved. The local healthwatch should publish an annual report on how it has been carrying out its functions over the preceding 12 months, including an assessment of how effectively and efficiently it has carried out those functions and of the changes to health care and social care services that have resulted.

We are offering some flesh to Government Committee members in terms of what local healthwatch ought to look like. On the face of it, it seems unlikely that they will vote against such an amendment. It is perfectly sensible and is offered in good faith.

Paul Burstow: I have no doubt that this is one of those amendments that attempts to improve the Bill, rather than undermine it. However, the amendment as currently drafted is not necessary, not least because the main thrust of the hon. Lady’s arguments seem to be about issues to do with requests and rights of entry to properties; she made that point at some length. It is worth drawing the Committee’s attention to a clause that we will reach soon, clause 171. It deals with the issues around rights of entry. For ease of reference, I should say that it is also covered on page 154 of the explanatory notes. I think that clause sets out a framework by which those matters and those questions can be properly answered.

But the amendment relates to clause 168. It sets out a number of new functions that the hon. Lady has described. That will affect local healthwatch organisations. Clause 168 amends the Local Government and Public Involvement in Health Act 2007 to include additional functions, building on those carried forward from the local involvement networks in section 221 of the 2007 Act. Section 221
sets out a duty for local authorities to make contractual arrangements to ensure that certain activities can be carried out. Currently, those activities are carried out by local involvement networks.

Clause 167 provides for the establishment of local healthwatch. Schedule 13 then makes provision for local healthwatch organisations, such as status, membership, general powers, exercise of functions and accounts. The schedule reflects the degree of flexibility that we have in mind for those organisations.

For hon. Members to add a detailed list of procedures is too prescriptive for these organisations. It would be unhelpful to them as they evolve and develop. Local healthwatch organisations need to decide locally how they will be transparent to local people. Earlier, we discussed the Government amendment that will ensure that they meet in public and that all their papers are public, too.

In response to our consultation “Liberating the NHS”, National Voices has said:

“There needs to be an integrated service at local level that provides all the support and guidance that people are likely to need, including complaints advocacy and support to individuals on choice, under the banner of ‘HealthWatch’. But it needs to be a local commissioning decision how this integrated service is best obtained—whether this be from one or more organisations.”.

The British Heart Foundation went on to suggest that

“the commissioning of HealthWatch services should be based on local needs assessment and on an understanding of the aspirations and priorities of local people.”.

The Government have a strong commitment to localism and greater transparency, which are central to the approach that we are taking to public service reform, so clear information must be made easily available so that people can make informed choices and compare and contrast the performance of different organisations. Demanding over-prescriptive inputs really is not the answer.

It might also be worth underscoring a point that I think the hon. Lady referred to. A statutory requirement is placed on local bodies to publish a constitution. That is the reason for the amendment, but

Emily Thornberry: I want to comment on the hon. Member for Stafford’s comment that, currently, LINks organisations are very variable in their standards. The amendment is trying to ensure that we strengthen and have a minimum standard. If we are saying that it is up to the local healthwatch to provide their own constitutions, that allows for some flexibility. The amendment ensures that key standards are included within the terms of reference.

Debbie Abrahams: I again, the missing piece of the equation with LINks was that there was no national body to bring together good practice, to disseminate that good practice and to provide support and guidance to these organisations. That is one of the strengths that we bring through our legislation.

The amendment is far from being prescriptive; it is simply trying to ensure that there is some consistency and openness in the operation and procedures of local healthwatch. That is the reason for the amendment, but I hear what the Minister says and he hears what I say. I will not be pushing the amendment to the vote. I beg to ask leave to withdraw the amendment.

Emily Thornberry: I wish to say more on schedule 13 stand part. Amendment 357 aimed to introduce procedures—

Emily Thornberry: The Minister says that we should not be overly prescriptive, but the amendment’s provisions on procedures are hardly that. They do not say how local HealthWatch should exercise its rights of entry; they say that it should publicise what it does and when it is going to exercise its rights of entry. They do not say what a constitution ought to be, but that it should simply publish its constitution.

The amendment is far from being prescriptive; it is simply trying to ensure that there is some consistency and openness in the operation and procedures of local healthwatch. That is the reason for the amendment, but I hear what the Minister says and I hear what I say. I will not be pushing the amendment to the vote. I beg to ask leave to withdraw the amendment.

Emily Thornberry: I wish to say more on schedule 13 stand part. Amendment 357 aimed to introduce procedures—

The Minister of State, Department of Health (Mr Simon Burns): On a point of order, Mr Hancock. May I seek your guidance? Have we completed discussions and dealing with the amendment? Are we now on a stand part debate, or are you amalgamating that into the amendment?

The Chair: No. The amendment debate is over, because the amendment was withdrawn.

Emily Thornberry: It is slightly confusing because when the Minister responded to my criticisms in relation to amendment 357, he expanded slightly outside its precise remit. Doing so made perfect sense, but I can see that there is confusion as a result.
I return to my central criticism that the schedule is not sufficiently specific. If we accept the provision, we pass legislation that enables the establishment of local healthwatch organisations. How do the Government envisage such organisations? How many staff will they have? How will funding work in different populations and areas? Dudley, for example, which is a metropolitan borough, has 306,000 people. How will a population such as that be served by a local healthwatch? What will be a sufficiently large—or small—organisation? My own borough of Islington has a population of 191,000—it is a metropolitan, inner-city borough. Again, what will be the staffing and funding levels?

If the provision is accepted, we will establish local healthwatch organisations in good faith, anticipating that the Government will do the right thing on regulation, and that local authorities will do the right thing when they establish the organisations. It is so important to get that right. Many leaps are to be made in good faith and we hope that everything will be all right—perhaps it will, but perhaps it will not.

How many people do the Government anticipate will be employed in Chelmsford, which is a non-metropolitan district with a population of 167,000? What will be a sufficient size for a local healthwatch? It is fair to raise such questions, because we are in the dock when it comes to establishing local healthwatch, which will be an important part of the architecture and an important part of ensuring that local patients’ voices are heard.

Jeremy Lefroy: I have a couple of points on healthwatch. I welcome the establishment of the organisations, but I bring a little experience from Mid Staffordshire to bear. I realise that this is not part of the Bill and will come forward in regulations, but to whom, precisely, will healthwatch be open? As a local councillor, I have learned that we restrict the pool of people from whom we can draw the volunteers who serve in organisations such as healthwatch. County council meetings, for example, are held during the day, so people who are in employment find it extremely difficult to take part, to become members or to stand for election.

It is therefore vital, when the regulations are introduced and implemented locally, that great care is taken to ensure that people who are in full-time employment, women—or indeed men—who stay at home with young children, and the disabled can be part of the body. We all have a great interest in healthwatch, but such people are likely to have an even greater one. From my experience, locally, members of LINks—or their predecessors—are greatly committed to the health service, but often the membership does not reflect the widest range of people.

10.25 am

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

Adjourned till this day at One o’clock.