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Schedule 13, as amended, agreed to.
Clauses 168 to 183 and 185 agreed to, some with amendments.
Adjourned till Tuesday 15 March at half-past Ten o’clock.
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Monday 14 March 2011

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

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The Committee consisted of the following Members:

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

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Thursday 10 March 2011

(Afternoon)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

Schedule 13

Local Healthwatch Organisations

1 pm

Question (this day) again proposed, That the schedule, as amended, be the Thirteenth schedule to the Bill.

The Minister of State, Department of Health (Paul Burstow): Before we adjourned my hon. Friend the Member for Stafford was speaking about the lessons we should learn from the way in which local involvement networks have operated when considering the future of healthwatch. One of the points that I take from his and other contributions is the importance we attach to ensuring that the seldom heard and hard-to-reach groups and, bearing in mind the comments of Mind, Rethink and others, people with mental health problems are properly engaged and involved in healthwatch. HealthWatch England will provide guidance about sharing best practice across the network of local healthwatches up and down England.

We were asked a number of questions about the funding mechanisms for allocating resources. Just as LINks do now, local healthwatch organisations will receive their funding via local authorities which, in turn, will receive their funding via the formula grant mechanism, so resources will be available for local authorities to discharge their duties to commission these services. The vision for local healthwatch is clear: it is to build on existing structures and experience and to make sure that we share the best practice. All of that has to be done and be firmly grounded in local determination—an approach that is backed by many of the stakeholders who felt that some of the previous iterations of public and patient involvement over the past decade or so were top-down and heavy-handed and have not enabled the patient voice to be articulated as strongly as we want. That is why central Government will not decide every last detail of the way these boards work.

The curious thing about amendment 357, which we discussed this morning, was how it highlighted the dichotomy in the Opposition’s approach to the Bill. On the one hand, they are worried about the Secretary of State appointing the chair of HealthWatch England, but on the other hand they seem to want to prescribe in minute detail the membership and operation of local healthwatch. That seems strange. I hope that the hon. Member for Islington South and Finsbury will feel that we have had a good debate on these issues and that I have reassured her enough that she will not press her amendment to a vote.

The Chair: There is no amendment. Question put and agreed to.

Schedule 13, as amended, accordingly agreed to.

Clause 168

Activities relating to local care services

Paul Burstow: I beg to move amendment 425, in clause 168, page 140, line 38, at end insert—

'( ) At the end of that paragraph, insert “and to the Healthwatch England committee of the Care Quality Commission.”'.

I apologise for the slight confusion just now. The amendment will ensure that local healthwatch organisations can make known to HealthWatch England the views of local people, as well as reports and recommendations. It will help HealthWatch England to fulfil its role as the national consumer champion for health and social care by ensuring that matters that are important to the public, patients and other users of care services can be brought to its attention.

Amendment 425 agreed to.

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 349, in clause 168, page 141, leave out lines 2 to 4.

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

Amendment 352, in clause 170, page 142, line 22, after ‘Independent’, insert ‘advice, information and’.

Amendment 353, in clause 170, page 142, line 22, at end insert—

‘(1) Each local authority must make such arrangements as it considers appropriate for the provision of advice and information about access to local care services and about choices that may be made with respect to aspects of those services.

(2) Where arrangements under subsection (1) provide for the local Healthwatch organisation for the authority’s area to provide the services or to arrange for their provision, the arrangements are to be treated for the purposes of this Part as arrangements made under section 221(1).’.

Government amendments 426 to 433.

Emily Thornberry: Amendments 349, 352 and 353 are designed to probe the various functions of local healthwatch organisations by offering further discretion to local authorities.

The problem is that local healthwatch members are being asked to do a number of jobs at the same time, many of which are contradictory. As part of local healthwatch boards, they will have commissioning responsibilities, but they will also have the jobs of providing information and advice on choices in local health and social care services; providing advocacy and a complaints service; and playing a role in policing local services—they will be doing it all. They will commission, say, social care in a local area, provide information on that care and police the care that they commissioned and provided advice on; and if anything goes wrong, they will also provide advocacy and complaints services in relation to the social care that they commissioned and provided advice on. It may be that they commission a service, advise someone to go to it, police it but fail in that policing, and thus generating a complaint for which they then provide the advocacy service.
Paul Burstow: I am grateful to the hon. Lady for giving way while she is developing her argument, but I hope that I can reassure the hon. Lady and others who might have concerns about the policy intention and the effect of the Bill. Our clear purpose is to amplify the voice of patients and carers in the system. They have a chair at the local authority table and on the health and well-being board for that very reason—to make that their voice is heard loud and clear at key points when discussions are taking place and decisions are being made on the local population’s future and current strategic needs for health and social care. In the framing and setting of priorities in the strategy that comes from that joint strategic needs assessment, again, we want to ensure that voice has real leverage, purchase and impact at the most important time. Like the JSNA, that strategy will be an important document because of the clauses of the Bill that place it into law, for the first time, the requirement that commissioners “must have regard to” it. We know that that is more than just words; it leads to legal interpretations. Looking at those two pieces of work will require a degree of rigour and evidence of rigour, so healthwatch will have a very important role locally.

The Opposition amendments in the group relate to the functions proposed in clause 168(3) to be given to local healthwatch organisations to provide “advice and information about access to local care services and the choices that may be made with respect to aspects of those services”.

Amendment 349 would remove that function from clause 168. Amendment 353 would relocate that aspect of clause 168(3) to clause 170, which deals with the independent advocacy services, which the hon. Lady touched on, but with the added provision that the local authority would “make such arrangements as it considers appropriate”.

Amendment 352 would change the title of the clause to, “Independent advice, information and advocacy services”. Therefore, those amendments would transfer responsibility for the advice and information functions from the local healthwatch to the local authority.

Clause 168 amends the Local Government and Public Involvement in Health Act 2007 to include those additional functions, which local healthwatch organisations will have to carry out. We want it them clear on the face of the Bill as responsibilities of local healthwatch, not matters for the local authority to subcontract to local healthwatch organisations. That includes the provision of information and advice to the public about accessing health and social care services and about choices in aspects of local care services. Providing information and advice is important if we are to ensure that the public and patients are given the information to help them to make the informed decisions we want them to be increasingly able to make.

1.15 pm

Emily Thornberry: The hon. Gentleman and I are in agreement on a number of issues. It is certainly important that people be given information, particularly about social care, and especially when they are self-funders. Far too often at our advice surgeries, we come across people who are self-funders and simply do not know where to go to find long-term care, so we must have a good source of information. However, there is a question in that.
As I understand it, the Government have changed their position on independent advocacy services in response to the consultation. They have allowed local authorities to respond to local needs and decide to take on the responsibility of advocacy services. In those circumstances, is there not the same argument in relation to information, so that information could be taken from healthwatch and put into local authorities? I do not suggest that one is preferable; I just want to understand the Government’s thinking.

Paul Burstow: The first point is that there is nothing in the current statutory and legal framework to preclude local government from commissioning other information and advice providers; it still has its powers to provide grants to citizens advice bureaux and many other organisations. That does not change. In that sense, transferring the responsibility from local healthwatch to the local authority merely transfers to local authorities something that they already have the power to do. We want to make it clear in the Bill that local healthwatch can do such things. The Government consider that to be an appropriate function for local healthwatch, not the local authority.

Local healthwatch organisations will be the local consumer voice. They will have the knowledge about local provision of health and social care services, and that will be important in helping people to find out more about the services. On the question of contradictory roles or roles that might stretch their skills and capabilities, HealthWatch England will provide leadership and advice to local healthwatch. It will make sure that there is appropriate support. That could include a framework for skills and training for local healthwatch, if that is deemed necessary. There is ample opportunity through the new arrangements that we are making at a national level to support the necessary development of skills.

We want local healthwatch to be instantly recognisable as a reliable source of information and expertise on health and social care while allowing for those functions to be carried out by local healthwatch. The amendment would not make it a requirement; that would lead to confusion for service users and members of the public who will not be able to rely on advice and information services being offered by their local healthwatchs.

Clause 168 sets out a function of providing advice and information about access to local care services and about choices that may be made with respect to aspects of those services. That will be a local healthwatch function. In providing that each local authority must make such arrangements only as it considers appropriate, amendment 353, in effect—I appreciate that it is a probing amendment—would dilute the current requirement. I hope that I have been able to offer the hon. Lady some reassurance and that she will not press the amendment.

Government amendments 426 to 433 are minor drafting or technical amendments relating to clause 170, to which we will come in due course. It relates to the provisions of independence advocacy that the hon. Lady mentioned just now. Clause 170 inserts new section 223A into the 2007 Act, which imposes a duty on local authorities to commission independent advocacy services, as they consider appropriate, for complaints relating to the provision of health services. A local authority may commission these services with a third party or arrange for advocacy to be provided by a local healthwatch.

Amendment 426 is a minor drafting correction. The current subsection (4) of new section 223A provides that a local authority may make arrangements, as it considers appropriate, in addition to arranging independent advocacy services, for the provision of assistance to individuals in connection with complaints about the provision of NHS services. The amendment simply moves subsection (4) to a better place. Amendment 429 is consequent to amendment 426 and is also a minor drafting amendment. It removes what was previously subsection (4), consequent on the contents of subsection (4) being moved.

Amendment 427 closes a potential loophole that would have allowed third parties commissioned by local authorities to arrange to provide independent advocacy services, to arrange for the provision of those services from a local healthwatch. Amendment 428 ensures that arrangements for local healthwatch to provide new section 223A services are treated as made under section 221(1) and that the service provision is treated as an activity specified in section 221(2).

Amendment 430 closes a gap in new section 223A. In arranging for the provision of services, the local authority needs only to have regard to the principle of independence in relation to the provision of services under the arrangements—for example, where the arrangements are between a local authority and a provider. The amendment will also ensure that the duty on the local authority applies in relation to the provision of services in pursuance of arrangements under new section 223A, where the local authority arranges for a person to commission the provision of services from another person.

Amendment 431 is another technical amendment. New section 223A(6) will enable a local authority to make payments to any person providing services under new section 223A, but as drafted it does not provide a power to make payments to a person who arranges the provision of those services. In certain cases, a local authority may wish to make arrangements under new section 223A for a person to commission services, and we do not want to prevent local authorities making such payments.

Amendment 432 will make a minor drafting change to new section 223A, to ensure that duplicate payments cannot be made. Amendment 433 will close a gap in the legislation, conferring regulation-making powers in relation to the duties of service providers to allow entry by LINks, which will be replaced by local healthwatchs. As drafted, an authorised representative must be carrying out a viewing or observation for the purposes of undertaking activities specified in section 221(2), under the arrangements in section 221(1). The amendment extends that by also providing for the viewing or observation to be carried out for the purposes of undertaking such activities in pursuance of the section 221(1) arrangements. I hope that I have clearly set out all those amendments for hon. Members and for the record. I end by saying that the hon. Member for Islington South and Finsbury will have noted the unprecedented transfer, made by the Government, of resources for social care from the NHS to local government, and the support that that provides the NHS.
The Chair: I missed part of that, Mr Burstow; I wonder whether you could repeat it without your crib sheet. [Laughter.]

Emily Thornberry: In response to the last point that the Minister made—gratuitously—I should say that I am sure that he is aware that the Local Government Group and the Association of Directors of Adult Social Services believe that there will be a £4 billion shortfall in the funding for social care. Our concerns are cumulative, continue and grow in relation to the next clause. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 168, as amended, ordered to stand part of the Bill.

Clause 169

LOCAL AUTHORITY ARRANGEMENTS

Emily Thornberry: I beg to move amendment 350, in clause 169, page 141, line 38, at end insert—

'(7C) Before preparing this report, A must consider such information and consult such organisations and persons as it considers appropriate, including an overview and scrutiny committee where operated. A must describe in the report the nature of the information considered and the names of the organisations and persons consulted. '

The Chair: With this it will be convenient to discuss amendment 351, in clause 169, page 141, line 39, at end insert 'and insert—

'(8) Before determining the arrangements to be made under section 221(1) the local authority must consult such persons and representatives of such persons as it considers can provide advice about arrangements that will secure the requirements in section 222(7A) and must have regard to the advice it receives when determining the arrangements to be made."'.

Emily Thornberry: I begin by apologising to the Committee for the amendments, but they are consistent with the Bill. I have to say that making the amendment refer to "A must consider" as opposed to "local authority" is unnecessarily obscure, but we need it for consistency.

It is a huge shame and a great missed opportunity that proposals should be put forward for establishing local healthwatches without there first having been a proper evaluation of LINks. What emerged from LINks was that a host often did not provide a proper understanding of community needs. I am sure that Members are aware of the written evidence submitted by the Patients Association. The eighth bullet point of point 6 states:

"We are concerned that there is an expectation there will be a free transfer from personnel in LINks to local HealthWatch. But we hear from patients phoning our Helpline that the local LINks are not working and that the service they are providing is substandard."

It goes on to comment on the transfer of personnel in LINks around the country.

The amendments seek to ensure that the local healthwatch consults widely on what its priorities should be and what the needs of the communities are, so that it is in the best position to put in place the appropriate resources right from the start. That is the purpose of the amendments. They attempt to strengthen local healthwatch, because it is in the interests of all of us that patient voice should be heard loudly, clearly, fairly and proportionately at a local level.

Paul Burstow: Let us start by dealing with the very fair point about the evaluation of LINks and how the Government intend to proceed; that will help the Committee as it considers the role of HealthWatch and how the Government are intending to develop that role. We are planning—as we are with the GP commissioning consortia—to establish a network of pathfinders to explore and to learn by doing under the current structures.

Just as we are working with colleagues in local government to encourage and support the establishment of health and well-being boards, so, too, are we planning a similar approach with HealthWatch. That, along with links to a number of action learning sets that will be established as part of the evaluation of the pathfinder activity, will be used to explore more fully the lessons learned during the pathfinder period and from the LINks around the country.

It is also worth noting—I suspect that this is the source of some of the points that the hon. Lady made—that the Centre for Public Scrutiny, the Patients Association and the Local Government Association are carrying out the very evaluation that she suggests is necessary. I understand that they will report their findings in May. Of course, we wait avidly to see what they find and how that will inform the practical guidance and support that HealthWatch England will be able to supply to healthwatch as it develops.

Emily Thornberry: May I make the obvious point? We have three groups looking into LINks and how successful they have been. We have another inquiry looking into what happened in Mid Staffordshire. We
need to learn from all that, and yet the Government
continue to force through legislation relating to national
HealthWatch and local healthwatch without the benefit
of learning from the experiences of people up and down
the country. Does not the Minister understand that it is
time to stop, listen and come back with better legislation?

1.30 pm

Paul Burstow: On the contrary, we are listening,
responding and, where necessary, making sure that the
Bill is improved. That has been the nature of the process
since July when we published the White Paper. We
consulted. We had 6,000 responses. We listened. We
understood the concerns and have addressed them in the
Command Paper and the Bill. There has been a
process of ensuring that the Bill is fit for purpose and
actually delivers the devolution of power in the NHS
that the Government believe is essential to liberate
front-line staff to deliver the best possible outcomes for
patients. That is something that the current system will
never be capable of doing, because of constraints and
impositions from the centre.

On local authority duties, clause 169 amends the
Local Government and Public Involvement in Health
Act 2007 to allow the local authority to set up a
contract with the local healthwatch organisation directly,
or with a host if it wants, to carry out the functions as
set out in section 221 of the 2007 Act, which includes
the new functions added by clause 168.

Amendment 350 seeks to place a requirement on the
local authority to consult persons as it considers appropriate
before it prepares its report on its findings on whether
local healthwatch arrangements are performing effectively
and delivering value for money. As part of its functions,
the local authority will assess and prepare a report
about the performance and value for money of those
arrangements.

Such information is important to the public purse
and to the local healthwatch organisations, which will
have a separate duty to operate effectively, efficiently
and economically. The amendments are unnecessary,
and, in reference to proposed new subsection (7C), if
the authority has considered particular information
and consulted particular people, we would expect it to
say so in its report.

Amendment 351 seeks to add a requirement on local
authorities to consult persons as it considers appropriate
before it prepares its report on its findings on whether
local healthwatch arrangements are performing effectively
and delivering value for money. As part of its functions,
the local authority will assess and prepare a report
about the performance and value for money of those
arrangements.

Nicky Morgan (Loughborough) (Con): I understand
the hon. Lady's point, and I am sure we are all aware of
good local authorities and bad ones. Does she not
think, however, that if there was an aggressive and
effective local healthwatch that felt its funding was
threatened, the first thing it would do would be to go to
the press? Any sensible local authority would not have a
battle in the public domain about funding.

Amendment 351 seeks to require local
authorities to consult persons as it considers appropriate
before it prepares its report on its findings on whether
local healthwatch arrangements are performing effectively
and delivering value for money. As part of its functions,
the local authority will assess and prepare a report
about the performance and value for money of those
arrangements.

Of course, we will also look carefully and closely at
findings of the work that the Local Government Association
is doing. Indeed, we are working closely with it on many
aspects of the implementation of the measures in the
Bill. The hon. Lady's proposals are too prescriptive.
They are matters that should be decided on locally by
elected local councils; they are not for Members to
prescribe in the House. Our approach is to encourage
local authorities to consult, and it is good practice to do
so. Local authorities must decide how it would work for
them.

If the amendments are not withdrawn, I invite my
hon. Friends to oppose them, but I hope that the hon.
Lady feels able to withdraw them.

Emily Thornberry: I will have more to say in the
clause stand part debate, but I beg to ask leave to
withdraw the amendment.

Amendment, by leave, withdrawn.

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

Emily Thornberry: I want to raise some other concerns
about clause 169 that have not fallen within the scope of
the amendments. The first is under the category of the
relationship between local healthwatches and local
authorities. What if there is a conflict of interest or a
disagreement? What would the local authority do?

The local healthwatch could be, for example, an
assertive, aggressive, argumentative and difficult organisation
that is giving the authority a really hard time, particularly
in the commissioning of social care. It could be in the
local paper every week, criticising the local authority
and having a go at the leader of the council and so on.
The local healthwatch, however, is dependent on the
local authority for its very funding and existence. One
hopes that the local authority, in all good will, will
continue to fund it properly and to give it support, but
there would be a temptation not to do that.

What would happen in those circumstances? What if
a local healthwatch was doing its job in an aggressive,
but nevertheless proper, way? If it does not have sufficient
independence from the local authority, how can it fulfil
its function? The local healthwatch has a particular
concern with social care, and it therefore has a job in
scrutinising what local authorities do in the commissioning
of social care. That is an important question, which
requires a clear answer from the Government.

Nicky Morgan (Loughborough) (Con): I understand
the hon. Lady's point, and I am sure we are all aware of
good local authorities and bad ones. Does she not
think, however, that if there was an aggressive and
effective local healthwatch that felt its funding was
threatened, the first thing it would do would be to go to
the press? Any sensible local authority would not have a
battle in the public domain about funding.

Do the hon. Lady's comments not also suggest that
she has little confidence in the ability of local authorities
and councillors to stand up to decent scrutiny? Is that
not rather insulting to all those hard-working local
authorities and councillors across the country that are
perfectly capable of dealing with effective scrutiny
committees and defending their policies if necessary?

Emily Thornberry: Given the appalling level of cuts
that local authorities are facing, many different organisations
will face the wall very quickly; I suspect the first in line
might well be those that are giving the local authority
the hardest time. I do not want that to be the situation,
and in an ideal world it would not happen, but we are
all living in the real world, at least on this side of the
Committee.
Dan Byles (North Warwickshire) (Con): Is the hon. Lady confirming that it is Labour party policy at the local level to make cuts based on political decisions, rather than try to make effective savings?

The Chair: That is going way beyond the scope of the Bill, and I would not want the hon. Lady to respond to it.

Emily Thornberry: I am not tempted to respond. I do not think that I could respond in language appropriate to the confines of this room, but I would be happy to talk to the hon. Gentleman about it afterwards.

One very serious question that needs a serious answer is: what happens where there is a conflict between local authorities and local healthwatch, because we are dealing with people? The second question is this: there is provision for one member of local healthwatch to sit on the health and well-being board, is that sufficient? It seems to be prescriptive that only one person from local healthwatch will be sitting on a health and well-being board. Is that really necessary?

I would like to read into the record further evidence from the Patients Association:

“Local authorities will be responsible for the performance of Local Healthwatch as the commissioners of this service. It will be the local authority’s responsibility to performance manage Local Healthwatch. There will be no nationally driven performance management of Local Healthwatch. How will consistent standards between Local Healthwatch be monitored?”

If that is right—perhaps the Minister could confirm that it is—the organisation responsible for performance management of local healthwatch will be the local authority. How can we ensure that there is consistency of standards across the country? Or will it be national Healthwatch that will monitor the performance of local healthwatch? That would be odd because national Healthwatch would be monitoring the performance, regulating it and ensuring there is best practice across country, but it would be paid for by another body. Being able to pay the piper is the source of much power. It is another example of tension between those two bodies. We want local healthwatch to succeed, rather than fail, but this seems to be a hole down which a local healthwatch could fall.

Local healthwatches need to represent all the views and experiences in their area, and they need to be able to gather views from across the population. There needs to be a range of ways in which people can get involved. Some LINks seem to have failed to create the community-focused approach we envisaged for their work. There is always a danger of capture by special interest and single issue groups. How can we ensure that there will be more genuine participation in the new local healthwatches? Will the Department of Health or local authorities provide guidance on how the views of the vulnerable and the hard-to-reach are expressed through healthwatch, because that seems to be an important area?

We do not just want to have the articulate, the motivated and the confident to be taking over these groups, nor do we want a subgroup of the area that feels particularly hard done by taking over, when there is a range of views that should be reflected by local healthwatch. How can we ensure that does not happen with this new organisation? Could the Minister offer us any guarantees? How will the views of the most vulnerable be fed into the system? Those are our concerns on local healthwatch and its relationship with local authorities. We want to have some reassurance from the Minister about how it will happen.

We are particularly concerned about a number of problems. I welcome what the Minister says about pathfinder local healthwatches. That is the sort of evidence-based policy making that we approve of so much—one of the reasons why we should not be pushing the Bill through as quickly as we are. Given that we are, that is perhaps one way of patching things up. I am pleased about that, but I hope that when we look at the performance of local pathfinder healthwatches, the questions that have been asked this afternoon will set the standard against which local pathfinders are measured.

Paul Burstow: Again, I suspect that the Committee shares the intention to ensure that the successors to LINks, local healthwatches, are effective bodies that provide a much stronger patient voice in the places that matter and in decisions about the health and social care provision in communities.

With regard to the hon. Lady’s questions, I shall start with the one about conflicts of interest, which is important to deal with. We have made clear in the Bill the duties of local authorities to establish healthwatches, the nature of their relationship and the safeguards to ensure that authorities do not overreach themselves and start to bully a healthwatch; that is the fear she described. It intrigues me because one group of amendments that we may consider in due course poses an interesting challenge.

A concern is that for example, a local authority might become so fed up with being constantly challenged by its healthwatch that it seeks to have it dissolved. We have provided an important safeguard against that in the Bill. A local authority, having established a healthwatch, will not be able to have it dissolved unless it agreed with HealthWatch England that that was the right thing to do and approached the Secretary of State to do so. That will provide a check and balance in the system and a view from HealthWatch England, and will secure the independent status of local healthwatches, which is important for their ability at the local level.

Emily Thornberry: Again, that sounds fine and dandy on the face of it. The difficulty is that although the local healthwatch might continue to exist and not be dissolved by a local authority disgruntled by its behaviour, the authority could starve it of funds or move its support elsewhere. As I understand it, there will be nothing that the national HealthWatch can do about that, and if I am wrong, I would be grateful for a reassurance. If there is a bad relationship between a local authority and a local healthwatch, will there be any way in which the national HealthWatch or anyone else can step in to ensure that the local healthwatch does not shrivel?

Paul Burstow: Let me try to ensure that we get that problem properly cleared up. People outside the Committee might have a legitimate concern about how the Government’s intention that local healthwatches be an independent and critical friend of the system can be secured. Local authorities will need to make funds available and will have a statutory duty to make arrangements to ensure that the activities mentioned in section 221 of the 2007 Act are carried out in their area, meaning that they have to provide any necessary funding.
The legislation will also require a local authority to make arrangements to ensure that the local healthwatch carries on with its activities.

We have also had discussions about the need to publish accounts—I have moved amendments to deal with that—and the need for transparency in understanding how resources are to be used. I am not convinced about the underlying case for a ring fence, as that can also become a constraint when it comes to the level of resources needed to provide a service. I hope that I have given the necessary reassurances about the statutory basis on which the provisions rest.

**Emily Thornberry:** May I say how impressed I am with the Government? The Minister was able to say with a straight face both this morning and now that a ring fence might constrain a local authority, as if in the current climate a ring fence would mean that local authorities would not be able to spend more than the Government intend. Given the terrible cuts that the Government are imposing on authorities, that simply will not be the case.

**Paul Burstow:** As the Government tackles the debt legacy we inherited it is undoubtedly the case that local authorities are having to deal with and make very difficult decisions, forced upon them by the fact that £1 in every £4 we currently spend in the public sector is borrowed. [Interuption.] I will move on very swiftly, Mr Hancock, to make other points more pertinent to the clause.

1.45 pm

Let us deal with the issue of membership and representation. The Secretary of State has a power to make regulations on membership if it is necessary to increase representation. The hon. Lady expressed her concern about there being only one member of the local healthwatch on the health and well-being board. It is important to stress again that in the Bill we provide the de minimis requirements for the membership of health and well-being boards. We do not want to be overly prescriptive in terms of all sorts of organisations that it might be good to have involved. It is very important that, in framing their governance arrangements, democratically elected local authorities that are accountable to their populations make and account for those choices correctly. They should make those choices, rather than MPs who sometimes miss things while adding longer and longer lists to the requirements. The current plans will allow the local authority to decide who and how many take part in the arrangements.

In terms of conflict between local authorities and local healthwatch, I think there will be a creative tension, but we are not trying to transfer—if you like—hon. Members’ experience of the adversarial system that we have in this place. We are trying to create a collaborative, consensual process that makes sure that the patient’s voice is heard, respected, understood and acted upon. That is what the Bill is all about. It is simply not possible for local authorities to starve these organisations of funds, as I have already set out, and of course HealthWatch England will be able to advise on the building of effective relationships with local authorities, should that become necessary. That is what these pathfinders are all about; making sure that we learn through experience and that that experience is disseminated throughout the system to get the very best of healthwatch into the system.

**Question put and agreed to.**

Clause 169 accordingly ordered to stand part of the Bill.

**Clause 170**

**INDEPENDENT ADVOCACY SERVICES**

Amendments made: 426, in clause 170, page 142, line 40, at end insert—

‘( ) Each local authority may make such other arrangements as it considers appropriate for the provision of services providing assistance to individuals in connection with complaints relating to the provision of services as part of the health service.’.

Amendment 427, in clause 170, page 142, line 40, at end insert—

‘( ) Arrangements under this section may not provide for a person to make arrangements for the provision of services by a Local Healthwatch organisation.’.

Amendment 428, in clause 170, page 142, line 42, leave out from ‘provide’ to end of line 45 and insert ‘services—

(a) the arrangements are to be treated for the purposes of this Part as arrangements made under section 221(1), and

(b) the provision of the services is to be treated for those purposes as an activity specified in section 221(2).’.

Amendment 429, in clause 170, page 143, line 1, leave out subsection (4).

Amendment 430, in clause 170, page 143, line 6, after ‘under’ insert ‘or in pursuance of’.

Amendment 431, in clause 170, page 143, line 12, leave out ‘; but this subsection’ and insert ‘and to any person arranging for the provision of services in pursuance of such arrangements.

‘( ) But subsection (6)’.

Amendment 432, in clause 170, page 143, line 13, leave out from ‘apply’ to ‘by’ in line 14 and insert ‘in a case where the person is a person to whom’.—[Paul Burstow.]’.

Clause 170, as amended, ordered to stand part of the Bill.

**Clause 171**

**REQUESTS, RIGHTS OF ENTRY AND REFERRALS**

Amendment made: 433, in clause 171, page 144, line 17, at end insert—

‘( ) In subsection (4), in paragraph (a), after “arrangements made under” insert “or in pursuance of”’.—[Paul Burstow.]

**Emily Thornberry:** I beg to move amendment 355, in clause 171, page 144, line 29, at end add—

‘(13) Section 226 of that Act, as amended by subsections (9) to (12) above, shall apply where a local Healthwatch organisation refers a matter relating to social care services to an overview and scrutiny committee of a local authority or to the authority itself where overview and scrutiny committees are all not operated.’.

This clause relates to requests, rights of entry and referrals, and amendment 355 seeks a commitment from the coalition Government on their intention to place all commissioners and providers of publicly funded NHS and social care services under duties to respond to requests for information and to comply with rights of entry.
Paul Burstow rose—

Emily Thornberry: A “yes” will do.

Paul Burstow: I may be a little longer, but I hope to get to that point very quickly. Section 226 of the Local Government and Public Involvement in Health Act 2007 relates to referrals of social care matters to health overview and scrutiny committees by local involvement networks, which are to be replaced by healthwatch organisations. The amendment would enable the referral of such matters to the local authority, where an overview and scrutiny committee is not operated locally.

We agree that it is appropriate to ensure that social care matters can be referred to such local authority areas. However, the amendment is unnecessary because proposed new schedule 16A(4) to the 2007 Act provides a general power for local healthwatch organisations, under which they “may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the exercise of its functions.”

That would include referral of social care matters to the local authority. In the light of that and with an indication that it is certainly our intention that, as now, such access should be available, I hope that the hon. Lady will feel able to withdraw the amendment.

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

Amendment, by leave, withdrawn.

Clause 171, as amended, ordered to stand part of the Bill.

Clause 172

Dissolution and transfer schemes

Emily Thornberry: I tabled amendment 356, which would have replaced “and” with “or”, but in the light of what the Minister said about dissolution of local healthwatch, the importance of there being some form of protection for those bodies and the assistance they may get from HealthWatch England, I have a better understanding of why we have the “and” instead of the “or”—or whichever way round it is—and I will not move the amendment.

Clause 172 ordered to stand part of the Bill.

Clause 173

Annual reports

Paul Burstow: I beg to move amendment 434, in clause 173, page 146, line 7, at end insert—

’(a) after subsection (2)(a) insert—

(2A) Provision under subsection (2)(a)(ii) is not to be taken as requiring H to prepare a report in relation to the provision by the Local Healthwatch organisation concerned of services under arrangements made under section 223A.’.

The amendment amends section 227 of the 2007 Act to clarify reporting responsibilities for hosts. A host organisation is a body that a local authority currently contracts with for the purpose of ensuring that local involvement networks’ functions are carried out. The Bill allows a local authority to decide whether to keep the existing host arrangements or contract directly with a local healthwatch organisation. If a local authority decided to continue the existing host arrangements, amendment 434 will ensure that the arrangements do not need to require the host to prepare annual reports on the provision by local healthwatch of independent advocacy services or other services under section 223A of the Local Government and Public Involvement in Health Act 2007. That is because arrangements for the provision of such services by local healthwatch would be separate to any arrangements under section 221 with the host to arrange for the local healthwatch to carry out its functions. The amendment makes it clear in the Bill that it is local healthwatch that discharges the function, not the host.

Amendment 434 agreed to.

Paul Burstow: I beg to move amendment 435, in clause 173, page 146, line 16, after ‘(4)’ insert—

(a) after paragraph (a) insert—

“(aa) the National Health Service Commissioning Board;
(ab) each commissioning consortium, whose area or any part of whose area falls within the area of the local authority;”,

(b) ’.

The Chair: With this it will be convenient to discuss Government amendment 436.

Paul Burstow: To ensure accountability and transparency, local healthwatch organisations will have to produce annual reports each financial year. Those reports will be sent to certain bodies, including HealthWatch England. The amendments clarify the requirements relating to the annual reports of local healthwatch organisations and are minor and technical. For those reasons, I hope that the Committee will support the amendments.

Amendment 435 agreed to.

Amendment made: 436, in clause 173, page 146, line 18, at end insert ’, and

(b) ’.

(Paul Burstow.)

Clause 173, as amended, ordered to stand part of the Bill.

Clause 174

Transitional arrangements

Paul Burstow: I beg to move amendment 437, in clause 174, page 147, line 1, at end insert—

'( ) Omit section 228 of the Local Government and Public Involvement in Health Act 2007 (previous transitional arrangements).’.

The amendment is minor, but technical and drafted in the spirit of good, legislative housekeeping. It removes the relevant section 228 from the 2007 Act, which made provision for transitional arrangements for local involvement networks. Clearly, that is no longer necessary—those transitional arrangements have been and gone. The amendment is simply a tidying-up provision that removes something that is no longer necessary.

Amendment 437 agreed to.

Clause 174, as amended, ordered to stand part of the Bill.
Clause 175

SCCRUTINY FUNCTIONS OF LOCAL AUTHORITIES

Emily Thornberry: I beg to move amendment 358, in clause 175, page 147, line 8, in the name of the Government.

The clause is important because of the substantial worries about what the Government are doing with overview and scrutiny, which, in some ways, are illustrated by the two amendments to the clause that we have tabled. Some of the arguments are complex and I hope that I can do them justice—I will do my best. We have a problem with the principle and whether overview and scrutiny will be able to refer anything other than changes to designated services to the Secretary of State for Health.

The amendment would exclude "omit an overview and scrutiny committee", for "the committee". In many ways, overview and scrutiny committees are highly successful vehicles, which gain a great deal of praise. I have received some agreed wording about the importance of overview and scrutiny, which essentially says that they are very far from being broke and certainly do not need to be fixed. It states that the "Centre for Public Scrutiny and the Local Government Group support the retention of the current arrangements—-independent health scrutiny committees that can determine the service changes they engage with and can make evidence-based referrals independently from executive and authorities."

Our concern is that the Bill will throw overview and scrutiny committees up into the air and allow local authorities to reorganise them. That is a walk into the dark that is simply unnecessary. The provisions of the clause are consistent with what I understand to be in the Localism Bill, under which all overview and scrutiny bodies are reorganised except, rather bizarrely, health overview and scrutiny committees—that Bill specifically excludes them. We have found ourselves in the odd position where the trust and confidence that the Department of Health has in health overview and scrutiny committees is much greater than the trust and confidence that the Department for Communities and Local Government has in health overview and scrutiny committees.

I do not want to draw obvious and unnecessarily—

Paul Burstow: Petty?

2 pm

Emily Thornberry: Very far from petty. Very important, in fact. I will spell it out. The Department of Health may not be terribly happy with keeping overview and scrutiny as currently organised because it is powerful. It is a way in which local communities are able to stop service reconfiguration in its tracks and send it off to the Secretary of State. The Department for Communities and Local Government has some respect for that and has specifically excluded it from the Localism Bill, but an attempt is now made in the Health and Social Care Bill to exclude the part of the Localism Bill that excludes it. There is an attempt to patch this up, but clearly in the two Bills we see clearly a disagreement going on between the Department for Communities and Local Government and the Department of Health. Perhaps those in local government have been able to lobby the Department for Communities and Local Government effectively so that the powers of overview and scrutiny committees are kept in the Localism Bill, but the Department of Health wants to chop its head off.

Concerns such as those may be some of the reasons why the Liberal Democrats are, according to the Evening Standard, in rebellion from the "top to the bottom" of the party over the Bill. [Interruption.] I am simply referring to what is in the papers right now and to what will be happening this weekend. The Minister has to answer those questions, because in the run-up to the Bill's passage through Parliament, he has been travelling up and down the country and saying in all the local papers that one of its purposes is to bring democracy to the heart of the NHS, but clause 175 conflicts with that. Much of my criticism has centred on the fact that, despite the promises, we are not getting an increase in democracy as the Minister has promised. The clause is much worse: not only are we not getting an increase in democracy, but it removes some of the best powers that local authorities have. That is our concern. Far from fulfilling the promises that the Secretary of State has made to his own Back Benchers that the legislation will increase local democracy, the clause shows that some of local authorities' most important powers are being taken away. It is important to have a clear answer from the Minister about what is happening.

As well as the conflict caused by the reorganisation of overview and scrutiny and health committees, a further difficulty is the removal of the power of local authorities to refer anything other than designated services to the Secretary of State. That is addressed in the next amendment, which I will come to next.

Paul Burstow: This is one of those debates where we are effectively debating the phantom Bill that the Opposition choose every so often to set up as an Aunt Sally that they can knock down, rather than addressing the Bill before us. This is definitely one of those areas where the rhetoric is intended to undermine rather than improve, strengthen or probe. That is understood, however, and it is taken in the spirit in which it is meant and, clearly, the spirit that was meant when the reference was made to the pleasant time that I expect to have with colleagues in Sheffield discussing this Government's health reforms.

To be clear, clause 175 amends the scrutiny provisions in the National Health Service Act 2006 to enable scrutiny functions to be conferred on local authorities instead of individual committees within local authorities. It also inserts a regulation-making power that allows the Secretary of State to establish the circumstances in which the authority may refer a matter on which it must be consulted to the Secretary of State and others. That power also enables the Secretary of State to issue directions in relation to referrals and to confer powers on the NHS commissioning board to direct consortia. It also—this is an important point, which the hon. Lady perhaps conveniently glossed over—widens the scrutiny of regulation-making powers so that they apply in relation to any provider of NHS services, in other words extending the notion that wherever the NHS pound is spent, that provider will be subject to scrutiny by a local authority in the future. It would have been valuable to have had that when the previous Government introduced the independent treatment centres. Perhaps we would have been in a better position to look at some of the cherry-picking that took place as part of that measure, as well as the extra costs and waste of taxpayers' money that was incurred as a consequence.
I am grateful for the opportunity to look at these issues, because they map out a critical difference in our approach. Amendment 358 would remove the flexibility for local authorities to choose how best to discharge their overview and scrutiny functions by enabling regulations to be made conferring such functions only on overview and scrutiny committees. I think that the hon. Lady and I have a shared desire to retain a clear separation between executive and scrutiny functions, which was a point made during the consultation on the White Paper, when we floated the possibility that the scrutiny role could be discharged by health and well-being boards. Local government and many others told us that they did not think that was a good idea, so we listened, understood, and changed it in the Command Paper, and that is now reflected in the Bill. We recognise that that original purpose was not to be achieved, but we are also clear that we do not want to create unnecessary, artificial barriers between different parts of the local authority scrutiny architecture. The amendment retains a top-down prescriptive requirement, which would act as a barrier to local authorities creating scrutiny arrangements shaped around their activities.

The phantom Bill cast before us today by the hon. Member for Islington South and Finsbury is not the real Bill that we should be debating. She raises the spectre of a difference of opinion between us and ministerial colleagues in the Department for Communities and Local Government taking the Localism Bill through. Let us be clear: the Localism Bill stipulates that in local authorities that operate executive arrangements, there must be a separate overview and scrutiny committee. We want that separation, but we also want to enable councils to develop health overview and scrutiny arrangements that can apply to any arrangements that the local authority chooses. They are democratic bodies which should be able to frame their own constitutions and governance arrangements and account to their electors for doing just that. We are clear that the clauses already prevent the executive functions themselves from scrutinising, while ensuring that the scrutiny function cannot be delegated to the health and well-being boards. Clause 175(2) ensures that we can give local authorities more say in their scrutiny functions, while ensuring, in combination with clause 180(4), that we achieve the necessary separation between scrutiny and the functions being scrutinised.

Emily Thornberry: Will the Minister have a stab at explaining why subsection (8) is drafted as it is? It states:

“In section 9F of the Local Government Act 2000”—which is somewhat presumptuous—

“(overview and scrutiny committees) (as inserted by Schedule 2 to the Localism Act 2011)—

(a) omit subsection (2)(f)”

Is that not where the heart of the battle is going on? As things stand, we may have a situation where, if the Bill is passed, the Secretary of State would be able to establish regulations to manage how overview and scrutiny is developed in health. However, we could have, under the Localism Act 2011—if that comes into being—further regulations also being sent out about overview and scrutiny by the Secretary of State for Communities and Local Government. There may well be a conflict between the two of them. How would the Minister seek to resolve that problem?

Paul Burstow: There is no such conflict. Government always act collectively and come to a view, which is presented clearly, cogently and powerfully. That is what we will do when it comes to dealing with such matters as we take the two Bills through the House.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Does my hon. Friend the Minister agree with this point? There has been a problem with overview and scrutiny committees in relation to local authorities and joined-up thinking, particularly on care of the elderly. When the overview and scrutiny committee in my local authority, for example, said that closing community hospitals was a bad idea, because we need to look after older people, have step-up care, step-down care, and respite care for cancer patients, the PCT was able to act independently against the interests of the wider community, and in fact against medical advice which the overview and scrutiny committee had taken on board. That is why things need to be changed, as the Bill is doing.

Paul Burstow: My hon. Friend makes a good point, which shows why we need to make such changes.

In this part of the Bill, we have also balanced the separation, giving local authorities greater flexibility to shape the scrutiny function to meet local needs. This provides local authorities with greater certainty, so that they can design their scrutiny arrangements with the medium and long-term in mind. We have not done that in isolation. This is not a way of diluting the crucial role of scrutiny. We have done this in response to the consultation, where respondents recognised the importance of scrutiny, and at the same time asked for greater flexibility. The Association of Directors of Adult Social Services, for example, said: “there needs to be local determination and flexibility to decide the best possible arrangements for scrutiny functions.”

Jessica Crowe, executive director of the Centre for Public Scrutiny, said in her response to the publication of the Command Paper:

“It is a tribute to the hard and constructive work of health overview and scrutiny committees everywhere that the government has recognised that their role should be not only maintained but extended.”

That is what we are doing with the Bill. We are making sure that it fits within the new architecture but is still clearly separate from the executive roles that are being established.

Emily Thornberry: As the Minister quotes the representative of the Centre for Public Scrutiny, may I cite the agreed wording between the Local Government Group and the Centre for Public Scrutiny? It states:

“The powers currently set out section 244 and associated regulations”—that is the overview and scrutiny powers—

“are possibly the strongest expression of democratic accountability in public services. They allow for robust, independent scrutiny of health care and health issues by elected councillors. Councillors on health overview and scrutiny committees can make independent reports and recommendations. They are a strong model for democratic accountability in public services—they should be retained and not diluted.”

How strong an endorsement is that? Why are the Government meddling with that in the Bill?
Paul Burstow: First, I do not believe that anything in the Bill or what we are attempting to do here diminishes or dilutes the scrutiny role. In fact, it extends the scope. That is what we are attempting to do here. I reject the premise that this is the pinnacle of democratic accountability when it comes to the reforms that we are making in the Bill. The changes in the relationship between the NHS and local government are brought about by the establishment of health and well-being boards and their new responsibilities to set joint strategic needs assessments and joint and health and well-being strategies. They are a further extension of democratic accountability, control and influence over the NHS that is very important.

Scrutiny is not about democratic control. It is about challenge and examination of what various other bodies that have specific responsibilities are taking forward. Early implementer health and well-being boards are very clear that their work is about increasing transparency and accountability to local people and communities, and effective scrutiny will be a key part of that.

Derek Twigg (Halton) (Lab): I understand what the Minister is saying. One of the challenges to the ability to scrutinise is the availability of information. The Minister or his colleague has made it clear that it is up to the consortia to hold public meetings and to decide what information they put in the public domain. Basically, the scrutiny board can call the consortia and other bodies to come before it, but it might not have all the information because the consortia can make spending decisions in private. There is a resolution before the Liberal party conference this weekend that no decisions about spending of NHS funds should be made in private by GP groups. Senior members of the coalition support that resolution. It is important when we are talking about transparency and accessibility that we consider the information that scrutiny boards can get hold of.

The Chair: We need to be careful. I know that there is a great deal of interest in this. I am sure that the hon. Gentleman would like a walk-on part at the conference in Sheffield, which could be arranged, but it is not really at the heart of this legislation. We need to temper our comments according to what is in front of us today.

Paul Burstow: I will follow that instruction. If the hon. Lady would like to attend, I am sure an appropriate bill could be sent to her for the charge of the appropriate rate for registration at a late time to attend the conference. It is a curious moment, when a Liberal Democrat Minister is dealing with this part of the Bill, to wind up debating amendments to a Liberal Democrats conference motion. That says something about how things change. I look forward to debating those amendments that we come to in Sheffield later.

It is a nonsense that the intentions of the Bill, and the words on the face of it, undermine our scope. Local authorities could continue to have overview of scrutiny Committees in their current form if they see fit. They will have to discharge a scrutiny role. We are saying that it should be up to those authorities how they do it. I do not understand the notion that we should not be prepared to trust autonomous, democratically elected local authorities to make decisions about their own governance arrangements, which is what the Bill enables. It does not remove the requirement that they do these things, but simply gives them the scope to decide how best to do it.

2.15 pm

Emily Thornberry: The whole point of overview and scrutiny committees is that they are at an arm’s length from local government. They are able to be in some ways independent. It is of enormous concern that local authorities will be able to look again at their overview and scrutiny committees generally, but the Localism Bill is not my concern here. My concern is the Health and Social Care Bill and the fact that local authorities may look again at overview and scrutiny committees and dilute them. That is not just the Opposition’s concern, but that of the Local Government Group and the Centre for Public Scrutiny.

Paul Burstow: In response to the consultation, we have given local authorities this flexibility—it is something that many in local government said to us. Many outside this Committee will note the level of Opposition Members’ distrust of their colleagues in local government and their ability and willingness to have a very clear separation between executive and scrutiny functions. Government Members are very clear that scrutiny is an essential part of the role of local authorities, both of the services they deliver and of those that the NHS delivers.

To the question about local authorities not having all the information they need to exercise scrutiny, again, the straightforward answer is no. We are extending scrutiny regulation-making powers to enable the scrutiny function to require information and attendance. They will be able to say, “You must come and you must provide information.”

Derek Twigg: On a point of order, Mr Hancock, is the Minister saying that no decision on spending by GP consortia will be taken in private?

The Chair: That is not a point of order.

Paul Burstow: The hon. Member’s question, which I am answering, was can a scrutiny committee ask—

Derek Twigg indicated dissent.

Paul Burstow: That was the question the hon. Gentleman asked first, and I am answering it.

Derek Twigg: The question was very simple. I said very clearly that the Bill accepts that GP consortia comes under the same scrutiny as other NHS bodies. The concern, expressed by members of the Minister’s own party, is that decisions on spending can be taken in private by the GP consortia and, therefore, the local authority and the scrutiny committee will not necessarily have all the information. If the hon. Gentleman is saying that no spending decisions will be taken in private by the GP consortia, I am happy for him to put that on the record.

Paul Burstow: I am saying that there is no information that a scrutiny Committee cannot ask of a GP commissioning consortia. That is the issue we are debating at the moment: scrutiny of health functions by local
authorities. We have already debated, Mr Hancock, the fact that GP commissioning consortia are required to produce constitutions setting out how their governance arrangements will work, and that those constitutions will provide more clarity and transparency than the system we have inherited from the Labour Government. The measures are about making sure that we can extend scrutiny to any provider who provides NHS services, to make sure that there is a level playing field and that local authorities can exercise the scrutiny role in a way that works for them and their community, rather than just for the convenience of the Opposition.

Emily Thornberry: I do not think I need to say anything else. I shall press the amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 33]

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

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

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil
James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

Emily Thornberry: I beg to move amendment 359, in clause 175, page 147, line 25, at end insert

'and in addition to any regulations relating to the referral of proposals for changes to services, the regulations may also provide for circumstances where referrals may be made either to the Board or the Secretary of State where local authorities or commissioning consortia are considered not to have had due regard to their duties to have regard to relevant health and well-being strategies when exercising their functions.'

The Liberal Democrats might be knocked from the top to the bottom in the revolt over NHS reforms because of the first put of the removal of the power of overview and scrutiny; they certainly will be when people learn about this. I would like the Minister's clear confirmation that my understanding is right. Will the legislation result in overview and scrutiny committees no longer being able to refer to the Secretary of State any changes of services that are not designated services? If he wishes to reassure me, I have little else to say.

Paul Burstow: indicated dissent.

Emily Thornberry: He does not, so I will go on. I appreciate that the mention of such things tends to result in a red mist descending in front of the eyes of some hon. Members.

To give an example, in my area of Islington, my local PCT, in its wisdom, decided to close the Finsbury health centre. My overview and scrutiny committee referred the matter to the Secretary of State after a great deal of to-ing and fro-ing, and attempts to deal with the matter locally. My PCT decided to consult not on the basis of whether the health centre should be closed, but on how it should be closed and where the various services should go. I have much sympathy with arguments that PCTs should be more democratically accountable, because that is the sort of issue that really gets people's goats. If the provision were about ensuring that PCTs were more democratically accountable, the Government would find support from many Opposition Members.

This is the difficulty: if there was an attempt to close the Whittington hospital's A and E department—given that it may not be a designated service—is it right that the overview and scrutiny committee would not be able to refer to the Secretary of State? It is of great importance and we need to know it. As I have said, the power that local authorities have to do that is one of the strongest models for democratic accountability in public services. It should be retained and it should not be diluted. If it is the case that only changes to designated services will be referred to the Secretary of State, we need to know that. In response to the White Paper, it seemed fairly clear that that was the Government's intention. Can we hear one way or the other what the situation is? It is of great importance to us all, not only in our Front Bench roles, but as constituency MPs.

Section 244 of the National Health Service Act 2006 also relates the duties of NHS bodies to consult relevant overview and scrutiny committees about proposals for substantial variations to services, known as service reconfiguration. Section 244 gives relevant overview and scrutiny committees the power to refer proposals for substantial variations to services to the Secretary of State for determination. Since 2003, those referral powers have been available for many service reconfigurations. It must be said that there have been few actual referrals. The local authorities have used their powers wisely and carefully.

The Independent Reconfiguration Panel has advised the Secretary of State about referrals from health and scrutiny committees. It praised the quality of the referrals that it has received in its report “Learning from the Reviews.” It has not been so complimentary about the NHS consultation process. So there we have another example. The Independent Reconfiguration Panel is telling us that local authorities are exercising those powers well. So why, why is the Bill taking away that power from local government? It would be interesting to know what the Secretary of State for Communities and Local Government thought about that, although we will not. We were hearing about his potential conflict on overview and scrutiny earlier. What the panel found suggests that health scrutiny committees can be the vehicle for building consensus around constructive change. Removing independence, resources and support from health scrutiny risks losing a crucial check and balance on the system, leaving communities with a weaker voice in service reconfiguration.

There has already been a great deal of debate on service reconfiguration issues during earlier debates. We are sure that there is concern on both sides of the Committee on how local services can best be protected under the Bill and how proposed changes can be quality assured in the way that they can be if local authority
overview and scrutiny boards are given a proper role. We are concerned that the regulations made under clause 175(3) could restrict councillors' referral powers to very a narrow band of designated services, meaning that the vast majority of services could be changed with very little democratic accountability.

Currently, overview and scrutiny committees decide which variations are substantial variations about which they wish to be consulted, that are subject to the referral power, even though that power is not often exercised. Restricting referral powers to designated services would mean that decisions about which service changes councillors could consider and refer would be taken out of local control. That would amount to a dilution of local democratic accountability.

There is also a concern that the regulations might also require decisions to refer to be taken by full council meetings. That risks breaching the principles of Wednesbury reasonableness. It would mean that councillors who had not scrutinised the issues or heard the full range of evidence, could determine the outcome. It would be impractical for a full council to seek to overcome that difficulty by carrying out reviews of service changes, of the kind currently undertaken by health scrutiny committees. Requiring votes at full council would also risk adding bureaucracy and delay to the process of reconfiguration. If the Minister can reassure us that regulations will not be introduced to ensure that the full council refers to the Secretary of State, we would like to hear that reassurance. I am sure that many people in Sheffield would want to hear that too.

The Centre for Public Scrutiny and the Local Government Group support the retention of the current arrangements and have helped me on the work that I have done on these amendments. They believe that independent health scrutiny committees can determine the service changes that they engage with and can make evidence-based referrals independent of executives and authorities. For consistency, they believe that health scrutiny committees should also be able to refer to the NHS commissioning board when they believe that commissioning plans do not have sufficient regard to health and well-being strategies. Will that be part of the regulations, too?

2.30 pm

“Equity and excellence” set out an intention to remove independent health scrutiny powers by vesting them in health and well-being boards. After reflecting on the outcomes of the consultation, the coalition recognised that that would be wrong. The was welcomed. The Bill retains separate health scrutiny powers for local authorities. The willingness to listen and to change, as I have said, has been welcomed, especially by the Centre for Public Scrutiny and the Local Government Group, which have campaigned on behalf of councils against locating scrutiny powers with the health and well-being boards. Given that those powers have been retained, why undermine them? Why allow something that works well, that ain’t broke? Why fix it in a way that takes away a great deal of the power? That is our genuine concern. We hope the Minister will be able to answer it, but we fear that he may not.

Clause 175 as drafted risks the loss of independent health scrutiny—which the coalition has already recognised would be wrong—by vesting the health scrutiny powers in local authorities themselves, rather than overview and scrutiny. As I have already argued, there is no guarantee that they will be fully independent.

Those are the difficulties and concerns. This is not a ghost concern, and it is not the Opposition arguing about a Bill that is, in some ways, a fantasy Bill. We are looking at the clauses, and we are not alone in our concerns. We want to have particular reassurance about whether or not non-designated services can be referred to the Secretary of State by overview and scrutiny. If not, why not?

Paul Burstow: This is a curious place to have the debate that the hon. Lady wants to have, because the amendment does not provide the scope for it and the intention to explore the issue of designation is not covered by these clauses. It is curious to revisit the issue at this point in the Bill.

I suggest that I deal first with the amendment and what it does and then address one or two of the hon. Lady’s points.

Paul Burstow: If I could just develop my point, the hon. Lady might not need to intervene.

I am again pleased to hear what the hon. Lady has said about the value of introducing the joint health and well-being strategy. She recognises that it is a valuable development. Although we can agree that such changes, which include the role of the health and well-being boards, are all very important, what we are also trying to do with the Bill is to ensure that the arrangements are proportionate.

Amendment 359 would enable regulations to provide for circumstances in which referrals may be made to the NHS commissioning board or the Secretary of State if the referrer feels the commissioning consortia or the local authority have not had regard to its joint health and well-being strategy. I entirely understand the policy intention that there must be some recoupment when it is felt that the local commissioners have not had due regard to the locally developed joint health and well-being strategy. That is what the amendment is about, which is why we have made provision in the Bill to enable the health and well-being boards to write to the NHS commissioning board if they are of the view that the consortia plans have not taken proper account of joint health and well-being strategies.

We are introducing a strong framework with clear incentives and a more robust basis for local integrated working than has been the case thus far. We do not want to undermine real and productive relationships by returning to the days of process set by Whitehall that looked to central Government to resolve matters that would have been much better resolved by local debate, local scrutiny and local decisions. These arrangements will make that more likely to happen.

Although the hon. Lady may want this to become a debate on designation, this clause and this amendment are not the place to do that. If I were to give lengthy answers to her questions, I would be straying well
outside the scope of the clause. I will give one piece of information to ensure that the hon. Lady feels that I have responded a little to her questions, notwithstanding the points that I have made about their being outwith the amendment.

How are local authorities involved in changes to NHS services? First, they will use the health and well-being board to discuss changes. Secondly, the local authority will use its scrutiny function to discuss changes. Thirdly, for service changes that are substantial or designated, the scrutiny function of the local authority can start a process of appeal. There are a number of aspects to that scrutiny function and it will be referred to the local council for a full vote.

As a former member of a local authority, I have dealt on a number of occasions over the years with other quasi-judicial roles that local authorities have. For example, in discharging planning functions, it is perfectly possible, without any threat of legal challenge, for a local authority to consider a planning application, for that matter to be referred to the full council by elected members and for it to be reconsidered and debated there without any concern about the matter that the hon. Lady described. I think that would equally be the case when it comes to a local authority, which, after all, is a body corporate that delegates functions to committees and other bodies. It will be able to do just that when it comes to this new responsibility that we are giving to the full council.

If the vote agrees to continue with the appeal, it is then referred to the NHS commissioning board. If the local authority disagrees with the commissioning board, it may then refer to the Independent Reconfiguration Panel and to the Secretary of State. The Secretary of State will ask for advice from the Independent Reconfiguration Panel. Acting on the advice, the Secretary of State can reject the appeal, ask for the proposer of the change to reconsider and consult, and, in some circumstances, stop the service change.

Undesignated services are obviously not subject to the third stage that I have just described. Every local authority must be consulted by Monitor—a very important point—on their designation guidance and by the relevant commissioners in applying that guidance once it is in place and is used to designate services. We will come back to the details. I do not propose to provide the detailed response to that debate, which we will properly have when we get to the relevant clauses.

Emily Thornberry: I want to make sure that I heard the Minister correctly. Is it the case that only designated services can be referred to the Secretary of State by overview and scrutiny? It is a simple question. Does the fact that the hon. Gentleman may not have been able to answer it directly, mean that I can assume that only designated services will be referred to the Secretary of State? Let me put it another way. Can the hon. Gentleman confirm that because he has not answered the question, we can infer that only designated services will be referred to the Secretary of State by overview and scrutiny?

Paul Burstow: Let me try one final time to answer. We have clauses later in the Bill that will provide a better place for this to be examined in detail. The question is about the referral of designated services. It is for local determination as to which services are applied to for designation.

Emily Thornberry: We know that.

Paul Burstow: I am just making sure that it is clear and on the record so that there is the clarity that the hon. Lady seeks. It is right that those services which are not designated should have more flexibility to reconfigure. We have debated that already. They will, of course, still be subject to section 242 duties to consult the public on changes to services, and overview and scrutiny committees will of course be able to conduct their scrutiny of such reconfiguration decisions. So the answer is yes, only designated, through regulations; but local authorities’ role in which services are designated is also very important. These are a series of interlocking clauses that provide a change in the nature of the scrutiny but actually strengthen it, because decisions about designation are ones that local authorities have a direct say over as well.

Emily Thornberry: I want to put the amendment to a vote and for it to be made perfectly clear that, as far as we are concerned, this is a vote on whether overview and scrutiny committees should be allowed to refer non-designated, threatened services to the Secretary of State. Anyone voting against the amendment is voting for non-designated services to no longer have that protection of being able to be referred to the Secretary of State, and that includes A and E departments in London.

The Chair: I am not altogether sure that that is what the amendment says. The amendment before us is quite clear.

The Committee divided: Ayes 9, Noes 12.

Division No. 34

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

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

Question accordingly negatived.

The Chair: May I say on behalf of the Committee, Mr Burstow, that it may be appropriate for you to write to the Committee, clarifying your answer to that last point, so that it is clear on the record for people inside and outside the House that we know exactly what the issue was. There could be some easy misinterpretation of that answer.

Paul Burstow: On a point of order, Mr Hancock. I am, of course, happy to do that and to make clear the reasoning behind why we felt that this matter would not be debated under this amendment.
Derek Twigg: Further to that point of order, Mr Hancock. I am not 100% clear about what you were saying. We do not have clarity as to why non-designated services are not included.

The Chair: That is the question to which the Committee and those outside Parliament would be interested to know the answer. It would be appropriate if we were written to on that point, so that it is clear.

Emily Thornberry: On a point of order, Mr Hancock. Given that the clause relates to the scrutiny function of local authorities, what is going to appear within the regulations and whether designated services or anything other than designated services will be able to be referred are things that are entirely within the remit of the clause. It is for that reason that we need to have complete clarity—

The Chair: That is a debate for clause stand part.

Paul Burstow: I beg to move amendment 438, in clause 175, page 148, line 31, at end insert—

'( ) Until the coming into force of paragraph 26 of Schedule 3 to the Localism Act 2011, section 21 of the Local Government Act 2000 (overview and scrutiny committees) is amended as follows—

(a) in subsection (2)(f)—

(i) omit “section 244 of the National Health Service Act 2006 or”,
(ii) for “either of those sections” substitute “that section”,
(iii) for “the Act concerned” substitute “that Act”, and
(iv) for “the section concerned” substitute “that section”,
(b) omit subsection (2A)(a) and (b), and
(c) in subsection (4) at the end insert “or under section 244(2ZD) of the National Health Service Act 2006.”

This is a transitional provision, which is necessary as we are contingent in part on the progress of the Localism Bill. The amendment will ensure that local authorities have flexibility in how they discharge their overview and scrutiny functions should we need to commence our provisions ahead of the commencement of the relevant provisions in the Localism Bill. Should those provisions be commenced before the commencement of our provisions, this transitional provision will not be necessary and the flexibility will be granted to local authorities through the amendments that clause 175 will make to the Localism Bill when it is enacted. For those reasons, I urge hon. Members to accept the amendment.

Amendment 438 agreed to.

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

The Chair: With this it will be convenient to discuss Government new clause 4—Amendments consequential on section 175.

Emily Thornberry: I believe that we have had such a complete debate that, tempting as it is, it would probably be wrong to go over it again.

Question put and agreed to.

Clause 175, as amended, accordingly ordered to stand part of the Bill.

Clause 176

JOINT STRATEGIC NEEDS ASSESSMENTS

Paul Burstow: I beg to move amendment 439, in clause 176, page 149, line 9, leave out

‘for which a partner commissioning consortium is established’

and insert

‘of a partner commissioning consortium’.

The Chair: With this it will be convenient to discuss Government amendments 440 to 442.

Paul Burstow: These minor and technical amendments will ensure that the representatives of the relevant GP consortia are required to be included in the health and well-being board, and that the amendments to the provisions on the preparation of the joint strategic needs assessment correctly refer to consortia.

As members of the Committee will know, commissioning consortia will set out their geographical area in their constitution. Any consortium that has a geographical area that overlaps with or is within the local authority area will have a duty to send a representative to the health and well-being board, and jointly prepare the joint strategic needs assessment and joint health and well-being strategy through the health and well-being board. The amendment makes it clear that references to consortia in the relevant provisions mean those whose area overlaps with or is within the local authority area.

As such, I hope that all the members of the Committee can see that that will ensure greater clarity and consistency with previous clauses and the engagement of all relevant commissioning consortia in the work of local health and well-being boards, and that they will therefore support the amendments.

Emily Thornberry: I make the simple point that the necessity to attempt to tidy up the Bill arises from the fundamental problem that GP consortia do not need to be coterminous with local authority areas. The difficulty is trying to ensure that strategic needs assessments are made in a way that makes sense in an area with a patchwork of GP consortia.

Paul Burstow: In briefly responding, I make the simple point that that is already the case with primary care trusts, many of which are bigger than a local authority or cover many local authorities, and in other circumstances the overlap is different. The problem is being inflated and exaggerated, as is so often the case with proposals made by the Opposition.

Amendment 439 agreed to.

2.48 pm

Sitting suspended.

2.55 pm

On resuming—

Emily Thornberry: I beg to move amendment 360, in clause 176, page 149, line 25, leave out from ‘consortium’ to end of line 26 and insert

‘must consult any relevant district councils in the area covered by the assessment and any other person, groups of people or representatives of persons or groups it considers can provide advice about the health and social care needs of the population of its area.’.
The Chair: With this it will be convenient to discuss amendment 366, in clause 176, page 149, line 25, leave out from ‘consortium’ to end of line 26 and insert ‘must consult the public and all interested groups following the Cabinet Office’s code of practice on consultations, making sure that consultation is an integral part of preparing its joint strategic needs assessment’.

Emily Thornberry: If we look at the clause, a fair caricature of what it is doing might be taking out “PCT” and putting in “partner commissioning consortia” instead. Essentially, it is updating the current joint strategic needs assessments, so that they are done by the local authorities and doctors, as opposed to by the PCT. I hope that that is a fair summary of the purport of the clause.

Nevertheless, the clause provides an opportunity to ensure greater accountability and more involvement by more bodies—bodies as diverse as the Optical Confederation, which contacted me, stating that it would wish to be one of the bodies consulted under the clause before a joint strategic needs assessment. That is why, in some ways, amendments 360 and 366, which come in at the same point, in effect make the same point: if we are putting together a joint strategic needs assessment, let us ensure that we do not only have the local authority and doctors discussing it, but a much wider group, so that we learn from everyone, including the opticians. We would have a proper joint strategic needs assessment, which was a distillation of the communal wisdom of an area.

Paul Burstow: The lead amendment would place a requirement on local authorities and commissioning consortia to consult with district councils as well as any other relevant persons, groups or representatives in the preparation of a joint strategic needs assessment. The amendment is unnecessary as section 116 of the Local Government and Public Involvement in Health Act 2007, amended by the clause, will require partner commissioning consortia and the relevant local authority—if a county council—to consult each relevant district council. The provision retains the current duty of local authorities and primary care trusts and recognises the important role of district councils in offering local insight and expertise.

We recognise the concern of the hon. Lady and of some district councils, but hope it is addressed by the reading across of existing provisions in the previous legislation. Moreover, consortia and the commissioning board will also be expected to consult the public as part of their obligations under section 242 of the National Health Service Act 2006 when planning for the provision of services. Local councils and consortia should have the flexibility to consult any person they think appropriate, as they do under the Bill. Decisions on whom to consult, beyond the statutory minimum, are best made locally and should be for local health and well-being boards.

Nicky Morgan: I entirely agree with what the Minister said about decisions on who to consult being up to local authorities, but I wanted to reflect some of the concerns expressed by various charities, including Rethink, which wanted confirmation that “any person” could include the local healthwatch organisation, as well as anyone else the authorities see fit to consult.

Paul Burstow: I am grateful to my hon. Friend for asking that. I can give her, Rethink and the other charities that posed the question the assurance that the provision does do just that. In addition, the local healthwatch, as a member of the health and well-being board, will be able to influence and recommend who else should be consulted about and included in the work around joint strategic needs assessments. The clause puts in place a double lock by providing for the local healthwatch to be consulted directly and for it to be able to ensure that the local authority and the consortia discharge their consulting role in a wider way.

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

Amendment, by leave, withdrawn.
Amendments made: 440, in clause 176, page 149, line 31, leave out ‘established for an area which’ and insert ‘whose area’.

Amendment 441, in clause 176, page 149, line 38, leave out ‘for which the commissioning consortium is established’ and insert ‘of the commissioning consortium’.—(Paul Burstow.)

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

Mr Kevin Barron (Rother Valley) (Lab): The Minister will be pleased to know that I am unable to be in Sheffield on Saturday afternoon, but my season ticket is available for Rotherham United versus Bury at the Sheffield Don Valley stadium. If he would like to borrow it, he might find more friends there than in conference.

The Minister says that the clause is about replacing PCTs with consortia, but it also extends the JSNA. Subsection (3)(c) says “after ‘a need’ insert ‘or to be likely to be a need’.” That is better described in the explanatory notes, which say that the amendments in the clause “also widen the scope of the joint strategic needs assessment to require it to cover both the current and future needs of the local population, and not only current needs.”

What is that likely to bring in? I presume that that is pointing to population health as opposed to health needs, but could he give us a brief description of how the assessments we have at the moment will be widened?

Debbie Abrahams (Oldham East and Saddleworth) (Lab): The Minister will not be surprised that my comments will relate to the importance of ensuring that there is an explicit reference to assessing comprehensive health inequalities, which I have raised a number of times in Committee.

The Bill has a particular weakness, because although it refers to the importance of health inequalities, and they are addressed under clause 3, the matter has not been well dealt with in relation to the mandate for the Secretary of State, the duties for consortia and so on. If we are committed to reducing health inequalities, there must be a more explicit reference in the Bill. We must have a comprehensive assessment that looks at not only the individual, but wider economic determinants. My concern links to a reference from the Faculty of Public Health, so other people regard the matter as a particular weakness, too. I hope the Minister will consider that and consider whether a designated person should be responsible for such assessment.

Paul Burstow: I shall start with the hon. Lady’s remarks on explicitly referring to health inequality within the discharge of the duty to produce a JSNA. It is important to keep in mind the simple fact that when particular organisations carry out any function that the Bill designates to them, such organisations must also have regard to the duties that are placed on them. They must exercise such regard through every function that they undertake. When discharging their function to produce a JSNA, they therefore have to demonstrate that they are also taking into account health inequalities. In addition, we intend to review and revisit the guidance on JSNAs and we want to co-produce that with colleagues in local government and more widely. We also want to ensure that such a review addresses the point made by the right hon. Member for Rother Valley about public health issues.

To answer the right hon. Gentleman’s question, we want to ensure that demographic trends are being understood and taken into account. Understanding such trends are a key part of determining how services might change over time to meet the changing needs of a population as a result of its ethnic mix, its socio-economic mix, and its age profile. We do not just want to get a snapshot of all those things in the here and now and then fix services on that basis. We need to be thinking into the future, too, as we are trying to ensure is clear in the Bill.

Debbie Abrahams: Again, I stress that these points were made through the Faculty of Public Health and arise from my experience. Why is there a problem with making the importance of health inequalities more explicit throughout the Bill? How will the matter be dealt with at the different stages? If it is not dealt with, there is a danger that health inequalities will not have the profile that is needed.

Paul Burstow: We will make absolutely certain that the guidance that supports the provision draws the attention of the parties that will produce JSNAs to the duty around health inequalities. It is a key part of the Bill, and this is the first time that a health Bill has contained an explicit reference to such inequalities—that has not existed in any previous NHS legislation. The duty must be exercised in any function that is discharged under the measures in the Bill, so it is a key part of the architecture. I am sure that hon. Members are right to keep raising the matter, and we are right to keep reassuring them. I am more than happy to have further conversations with the faculty about its particular concern, if it wishes.

The key point is that when producing JSNAs, consortia must take account of the relevant needs of the population, so they will have to take into account the health inequalities that exist. The strategy will set out how they will reduce such inequalities, and we would expect a joint health and well-being strategy to do that.

Debbie Abrahams: What about having a designated person responsible for assessment?

Paul Burstow: With regard to a designated person being responsible for producing the joint strategic needs assessment, we have made the organisational responsibilities clear in the Bill. Given the thrust of the Government’s intention not to be over-prescriptive in autonomous organisations’ governance arrangements, it would be odd to prescribe in the Bill a specific person as responsible, but it is a clear function and duty for them to discharge. With that, I hope that the clause can be approved.

Question put and agreed to.

Clause 176, as amended, accordingly ordered to stand part of the Bill.
Clause 177

JOINT HEALTH AND WELLBEING STRATEGIES

Grahame M. Morris (Easington) (Lab): I beg to move amendment 221, in clause 177, page 150, line 19, at end insert—

'(4A) In preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must have regard to the most recent assessment of housing need undertaken by the local planning authority.'

The Chair: With this it will be convenient to discuss amendment 221, in clause 178, page 151, line 16, at end insert—

'(fa) the officer principally responsible for the exercise of the local authority's housing functions, or if thought fit, a representative officer of a registered provider of social housing.'

Grahame M. Morris: The clause would impose a duty on local authorities and commissioning consortia to produce a joint health and well-being strategy to meet the needs identified in the joint strategic needs assessment. There will be a duty on consortia, the local authority and the NHS commissioning board to have regard to the joint strategic needs assessment and the joint health and well-being strategy when carrying out their commissioning functions.

The amendments would extend the duty to ensure that those strategies take account of some of the most important determinants of health. My hon. Friend the Member for Oldham East and Saddleworth just referred to health inequalities. In a similar vein, the amendments intend to be helpful and strengthen the provisions.

Amendment 220 is designed to ensure that, in preparing local health and well-being strategies, health and social care needs are considered alongside local housing needs. It would give regard to local assessment of housing needs. To reassure coalition Members, I should say that the amendments would not divert resources in a particular direction. They would give an opportunity to address health inequalities by identifying that particular need. It would also ensure that local partners could make this key determinant of health a priority when joint health and well-being strategies are being put in place.

Amendment 221 would ensure that a housing representative sits on the health and well-being boards. That person might be a director of housing or a chief executive of a housing association, in the cases where stock has already been transferred. Boards are expected to put in place a health and well-being strategy for their local area and to work in an integrated manner. To achieve that, a housing representative should be on the local board, alongside people representing social services, children's services and other representative board members set out in the legislation, because housing is a key determinant of health.

Mr Steve Brine (Winchester) (Con): I do not doubt the hon. Gentleman's motives, and he is making his point well. In my area, the city council owns stock and there are at least two—on the edge, three—other housing association providers. Does the hon. Gentleman propose that only the council's housing representative should sit on the board, or would there be four individuals?

Grahame M. Morris: Without getting into an argument about numbers, I should say that it would be sensible to have a representative. I do not think it would be problematic. In my area, we have a large arm's-length management organisation in respect of local authority housing stock. There could be a consensus on the representative among the providers, as long as we had somebody there with the expert knowledge to contribute.

The Committee should also be aware that any assessment of housing needs will be removed by the Localism Bill. The Minister might want to address that point later. My understanding is that that would mean there would be no local needs assessment to guide and inform what is decided and prioritised in local housing strategies. It is interesting that the National Housing Federation suggested that that contradicts the approach taken by this Bill—a point made eloquently by my hon. Friend the Member for Islington South and Finsbury. Needs assessment remains important for integrating services and prioritising the appropriate measures.

3.15 pm

By accepting the amendment, we could ensure not only that housing need informs local health and well-being strategies, but that there is some sort of assessment of local housing needs in the first place. I appreciate that housing need varies from area to area. For example, in my own constituency—a traditional coal mining area—we have a particular need for special-purpose accommodation because of a large and growing elderly population, many of whom have disabilities. Clearly, that has implications for health provision.

Each area has its unique problems. In areas such as Dudley or the London borough of Islington, where the populations are younger, there may be demand for more family accommodation. The amendment would not be prescriptive; it would be left to local determination to assess housing need and take appropriate action.

The amendment might be the only way to get the assessment of local housing need on to the statute book, because, to the best of my knowledge, the Localism Bill does not currently legislate for that, although I stand to be corrected. The Department of Health team may be unaware of the issue, and the amendments offer a vital opportunity to address the problem.

Such an assessment would benefit integration, cost-effectiveness and savings, and give more credibility to local health and well-being strategies. It may sit uncomfortably with the Government to enforce the membership of housing representatives on the health and well-being boards, but it could be of invaluable benefit for determining health needs. It would make sure that the relevant people were at the table to make vital decisions and have input into formulating strategy.

If the Government are serious about integration, as the Bill implies, the amendment should help them to realise that aim. Proper integration across health and social care cannot be fully achieved without considering the role of housing and support. Indeed, National Housing Federation research shows that currently only 20 PCTs are—using the term—collaborative working indicator, which is not good enough. As the new health service comes into focus, this picture must be improved. The amendment offers a mechanism for doing so.
Both sides of the Committee agree that there should be better integrated and co-ordinated services, so I would like to share some relevant facts and figures, which the National Housing Federation has provided. Housing-related support services—funded through the Supporting People programme, as Members will realise—save the NHS around £3.15 million each year, according to Government figures. Some 42% of social housing households have a resident who is disabled or has a limiting long-term illness, compared with a national rate of 17%. One community-based falls prevention scheme—which might even have been the one in my own area—reduced the rate of falls among older people by 55%.

Housing problems are frequently cited as a reason for a person’s being admitted or readmitted to in-patient mental health care. The need to find appropriate accommodation and a lack of appropriate move-on housing are major reasons for delays in discharging people from hospital back into the community. In an average homelessness project in England, an estimated 43% of clients are likely to have mental health needs and 59% may have multiple needs.

I point out to Government Members that the Government will be looking for local authorities to deliver cost-effective and value-for-money solutions to health challenges. For Opposition Members, putting housing needs at the top of the agenda would help to deliver more efficient health services, so I hope the Minister will look kindly at the amendment.

Paul Burstow: I am more than happy to confirm that when it comes to the representations that the National Housing Federation is making about the essential contribution that housing makes to good health, the hon. Gentleman is absolutely right. We do not disagree with that contention in any way. Our difference is over how we give effect to recognising that that is the case.

The difficulty with the amendment, as was pointed out by my hon. Friend the Member for Winchester, is that, given the large amount of housing provided by registered social landlords, and in some cases because of stock transfers, it would be challenging at the very least to decide who should sit on the health and well-being board. That is why prescribing membership in the way that the amendment seeks to is not the answer.

Dr Poulter: Does my hon. Friend agree that there is a big problem, and not just in the social rented sector? The worst housing is often in the private rented sector. It is particularly difficult to find any representation from that sector, so finding a coherent representation on housing would be difficult.

Paul Burstow: It is also why, in an earlier debate, we referred to and gave reassurances about the obligations on local authorities to consult with districts when discharging those responsibilities. They have environmental health responsibilities that will be relevant to concerns about housing in the private sector.

Grahame M. Morris: Just because a problem is difficult, it does not mean that we should not try to address it. In my area, we set up a taskforce with various key working groups, housing being one of them, and there is ample evidence that it was not difficult for the private and public sector to work together and have a representative. It is perfectly possible to do that, and it clearly identifies the issue on the agenda.

Paul Burstow: We have great trust in the wit, wisdom and ability of health and well-being boards and local authorities to make judgments about who would be the most appropriate additional members of a health and well-being board. We have set out the de minimis requirements in the Bill, not the de maximis position that everyone must be on the board. The danger with adding extra members to the board in the provision is that it narrows the local authority’s scope to make rational choices about who should sit around that table, contributing to these very important roles.

On the point about making sure that housing is properly taken into consideration in joint strategic needs assessments and therefore informs joint health and well-being strategies, the current guidance says that all factors impacting on the health and well-being of residents in an area should be considered. We intend that to continue. It rightly addresses the fact that there are many factors that affect public health needs and the social care needs of that population. The amendments would not give local authorities, through health and well-being boards, the necessary flexibility to deal with their local circumstances. That is why we resist them; it is not because we have a disagreement about the importance of housing. We do not. There is simply a need to ensure the right level of flexibility in approaching the issues at a local level.

Grahame M. Morris: I think we have covered the ground. The amendment was an attempt to be helpful; I regret that the Minister cannot accept it. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Emily Thornberry: I beg to move amendment 367, in clause 177, page 150, line 23, leave out ‘may’ and insert ‘must’.

My weasel word detector picked up this “may”. It is completely unnecessary; it should be “must”. We all know that if we want to make a big difference to health care, we have to integrate health care and social care services. It is completely unnecessary to use “may”, which is far too weak a word. We should have “must” instead.

Nicky Morgan: I want to put on record the fact that I have also been contacted about the amendment by several organisations. I have tried to amend various bits of legislation in my life before I came to the House, and this is sort of proposal I would always put forward. I am sure that the Minister will give us a full explanation of the current wording. Parliamentary draftsmen take their jobs extremely seriously and there are definitely rules and guidelines on why they tend to use such words. Mind and other charities want an explanation. The change could run right the way through the Bill. I am sure that there is a good reason why it does not, and I look forward to my hon. Friend’s explanation.

Paul Burstow: Let me try to reassure the Committee and give an explanation, as I have been invited to do.
The amendment would require local authorities and commissioning consortia to include a statement in the joint health and well-being strategy of their view on how health-related service commissioning could be more closely integrated with other health and social care commissioning in their area. Currently, local authorities and their consortia partners may include such a statement in their strategy, but are not forced to do so.

The intention behind the wording was not to be weaselly, but simply to follow parliamentary drafting conventions. The intention was to give local commissioners the flexibility to decide whether such a statement was helpful for their locality, rather than forcing them to include it. It reflects more broadly our approach of allowing them to shape the joint health and well-being strategy to reflect local challenges and priorities. The respondents to the consultation were generally very supportive of the flexible approach that we proposed, and we found no appetite for a more prescriptive approach driven from the centre.

Emily Thornberry: The Minister tells us that it will be up to local authorities to decide whether it is more appropriate for their locality to have better integration of health and social care. Has he any particular locality in mind that may benefit from there not being more integration between health and social care?

Paul Burstow: I am sure every locality will benefit from the integration of health and social care where that integration is appropriate. That is exactly what the Bill sets out to achieve with the new responsibilities that we are giving to the National Institute for Health and Clinical Excellence by extending its remit to social care. That is set out in the clauses that give the NHS commissioning board a duty to promote the integration of services and use of the National Health Service Act 2006 flexibilities on commissioning, and in the clause that we are considering, in respect of the health and well-being board. Integration is very much hardwired into the architecture of the Bill and is part of what we want health and social care commissioners actively to consider as part of their work on joint health and well-being strategies.

For local integrated working to be effective, there needs to be a minimum of central duties, especially unbalanced central duties, and the maximum space for local commissioners to build relationships based on trust and mutual respect. That is what we have learned from the fact that the existing flexibilities, which have sat in statute for many a year, have not been as extensively used as I am sure the previous Government hoped. We intend the clauses to make sure that there is much clearer focus on that, and much better working relationships in the system at a local level.

We will talk a great deal more about integration under later clauses, especially when we deal with amendments tabled by the hon. Member for Islington South and Finsbury to clause 179. However, I hope that I have been able to reassure her that we continue to listen, and that we want to make sure that the Bill achieves our intention of having greater integration of services and commissioning.

Emily Thornberry: The Minister says that the integration of health and social care is hardwired into the Bill. That is another one of his well honed and florid phrases that sounds great, but the provision is not hardwiring. It is as soft as it can be. It states:

“The responsible local authority and each of its partner commissioning consortia may include in the strategy a statement of their views on how arrangements for the provision of health-related services in the area of the local authority could be more closely integrated with arrangements for the provision of health services and social care services in that area.”

If that is hardwiring the integration of social care and health care, I am a monkey’s uncle. I want to press the amendment to a Division.

3.30 pm

Question put. That the amendment be made.

The Committee divided:

Ayes, 9, Noes 12.

Division No. 35

AYES

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

Question accordingly negatived.

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

Emily Thornberry: My point is simple. Clause 176 allows for joint strategic needs assessments and clause 177 allows there to be a joint health and well-being strategy, which is presumably informed by the joint strategic needs assessment. We have a strategy and an assessment, but we do not have any obligation to do those things. Clause 177 imposes a duty on the local authority and the partner commissioning consortia to prepare a strategy, and clause 176 imposes a duty to carry out an assessment. Under proposed new section 116B of the Local Government and Public Involvement in Health Act 2007, however, there is a duty to have regard to assessments and strategies:

“A responsible local authority and each of its partner commissioning consortia must, in exercising any relevant functions, have regard to...the most recent assessment of needs and...the most recent joint health and wellbeing strategy.”

That gets to the nub of things, and it is the reason why, from top to bottom, the Liberal Democrats are in full revolt against the Bill.

There is much agreement about having more democratic accountability for health authorities. However, the Bill sets up health and well-being boards that are in some way democratic—in one way, there will be some form of democratic accountability there—but have no power; and there are to be GP consortia, with all the power and no democratic accountability. The two of them come together for joint strategic needs assessments, when they
do their strategy, but there is no obligation for the commissioning consortia, who have the power to implement the strategy—certainly in relation to health—to actually do that.

As far as we can see, if a GP consortium does not want to do something, no one who represents the locality—not the local authority or the health and well-being board—can force GPs to do anything. The national commissioning board can, but it is made up of exactly the sort of so-called faceless bureaucrats that the legislation is supposed to take power away from, to give it to local areas instead. If all we have is a strategy and a needs assessment, but no power to ensure that commissioning consortia implement the strategy, what is the point? It is simply a talking shop, and that is the problem. Health and well-being boards are being set up to fail.

Much is said about how we are going to bring democracy into the NHS and decision-making down to a local level. From my reading of the legislation, it seems that the only decision-making about health that has been brought down to a local level is that doctors will be able to sit down with patients and make decisions. Any influence that health and well-being boards have on commissioning consortia is minimal. There certainly does not seem to be any power to ensure that the strategy that they agree together is implemented. That is yet another weakness in the Bill. If the Government are serious about bringing democracy into the NHS, why do we need to have such a pusillanimous clause as this?

Paul Burstow: Again, we are debating the phantom Bill that the Opposition would like people to think this is, and not the actual Bill that we are taking through Committee and the House. If one simply looked at the clause, one might give some credence to the hon. Lady’s argument, but it really does not bear too much weight. In the Bill we are, for the first time, putting on a statutory basis something that local governments said they wanted. They said that they wanted statutory health and well-being boards, and we have responded. They will be responsible for producing joint strategic needs assessments. At the moment, local authorities and primary care trusts produce those documents. One needs assessments. At the moment, local authorities

On top of that, we are talking about two separate and sovereign organisations: the NHS, with its responsibilities nationally to provide a comprehensive service and to spend taxpayers’ money, provided by the NHS commissioning board; and local authorities, with their responsibilities for commissioning social care with the resources provided to them. The health and well-being board effectively brings those two organisations together to agree the issues on which they need to work together and to ensure that health needs are assessed and then properly met.

The health and well-being board needs to be consulted on the commissioning plan of the GP consortium. If the health and well-being board takes the view that all the things they had spent time working on together had been ignored, it can make that absolutely plain. That would be taken into account by the NHS commissioning board. I think the hon. Lady is suggesting that what is needed is a collaborative and co-operative set of relationships between the NHS and local government.

The extraordinary thing about the provisions is how positively local government has responded to them. Local government sees that the provisions represent opportunities to move forward the agenda on public health, to move forward on the need to integrate public services for health and social care better, and to act as system leaders. Local government sees that, and it is signing up for it, and I am very sorry that the hon. Lady does not feel able to do so. That is why we have rejected the notion that we should be over-prescriptive, which is what she suggests we should be.

The provisions reflect the fact that for far too long, while in government, the hon. Lady and her party took the view that local government was simply an agent doing what central Government told it to do. That is not the Government’s view; our view is that local government has its own mandate and its own right to take forward the needs of its local population. The Bill recognises, respects and builds on that.

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

The Committee divided: Ayes 12, Noes 9.

Division No. 36]

AYES

James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Soubry, Anna
Sturdy, Julian

NOES

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

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

Question accordingly agreed to.

Clause 177 ordered to stand part of the Bill.
Clause 178

Establishment of Health and Wellbeing Boards

Emily Thornberry: I beg to move amendment 368, in clause 178, page 151, line 14, leave out ‘a representative’ and insert ‘representatives’.

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

Amendment 369, in clause 178, page 151, line 16, at end insert—

‘() the director of housing services for the local authority,
() a representative of the police service for the area of the local authority.’

Amendment 361, in clause 178, page 151, line 18, at end insert—

‘() a representative of any relevant district councils’.

Amendment 370, in clause 178, page 151, line 28, after ‘appoint’, insert ‘more than’.

Amendment 371, in clause 178, page 151, line 31, leave out subsection (7).

Emily Thornberry: Before the Minister tells me that we are being over-prescriptive, may I ask him why it is that when the Bill establishes all kinds of boards and organisations there is no spelling out, but when it comes to local government—when it comes to the heart of the measure and to everybody allegedly being brought together—the Government are being as prescriptive as they are? In giving us this great long list of all the people who should be on the health and well-being board, they should at least get it right. That is why we have tabled the amendments.

3.45 pm

For example, the Government prescribe that the health and well-being board should have “a representative” of the local healthwatch organisation for the area of the local authority. Why only one? Why should we not have “representatives”, which is what we propose in amendment 368? Amendment 369 raises the question why, if we have a representative of each relevant commissioning consortium, should we not also have a representative of people involved in housing and a representative of the police? In modern life, the police probably have a great deal to do with people with mental health issues, as well as expertise in the local area.

Government Members appear to be having very different reactions to that point, but the reality is that many anti-social behaviour problems arise because people have mental health problems and cannot relate properly to their neighbours. In the end, there is a problem of how to deal with such people. Their condition may not be sufficiently acute for an emergency team to be brought in, but if their neighbours find such behaviour difficult, they might involve the police. In some areas, therefore, the police have a better understanding of the mapping out of acute mental health problems, so it would be of value to have the police’s wisdom and advice on the health and well-being board.

Dan Byles: I make this point in a genuine attempt to help the hon. Lady. I sat on the board of a mental health trust and several of its committees and sub-committees, and although we often liaised with the ambulance service and the police, we found that it was incredibly difficult to get the police to be regular attendees at committees or sub-committees because they were so busy. They preferred to be invited when specific issues were to be discussed, rather than to be standing members. They were very resistant to being standing members on any of our committees or sub-committees.

Emily Thornberry: I am grateful to the hon. Gentleman for giving us that interesting information.

We argue that other people ought to be considered, as well. Representatives of district councils are also experts in their area, and should be included.

Nick de Bois (Enfield North) (Con): I sense that Opposition Members regularly feel the need to prescribe for just about every option. It strikes me that clause 178(8) leaves health and well-being boards discretion in whom to invite—basically, they can invite pretty much anyone to come in. We must assume that people will act in the best interests of their residents and take advantage of that provision, if the circumstances arise.

Emily Thornberry: Clause 178(8) is not a stand-alone clause stating:

“The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.”

The clause also contains a detailed prescriptive list, so I am asking why the Government include some people but not others. In this Committee, it is important that we prise from the Government why they have chosen certain bodies and not others.

Amendment 370 relates to subsection (5), which states “Local Healthwatch Organisation for the area of the local authority must appoint one person to represent it on the Health and Wellbeing Board.”

Again, why does the local healthwatch organisation have only one representative, given that we have heard from the Minister how important that body is? If the Government prescribe that there is only one representative, will health and well-being boards not feel unable to appoint more than one? If there can be more than one, why does the provision state “one?”

The most important and telling provision in the clause is subsection (7), which strikes me as extraordinary. It states:

“A person may, with the agreement of the Health and Wellbeing Board, represent more than one commissioning consortium on the Board.”

According to the explanatory notes, it seems that the provision is made out of consideration for doctors or those from commissioning consortia who may be terribly busy and have more important things to do than to appear on health and well-being boards. In a local authority area with two or three commissioning consortia, the Bill, if unamended, will allow one representative of all the commissioning consortia to join the health and well-being board—because that is more efficient, perhaps. An alternative explanation is that health and well-being boards are only a cover, and will not have the sort of power that the Minister claims they will. Although the boards are supposed to be accountable, they may actually be powerless, and perhaps we do not want such bodies to impinge too much on the time of doctors, who are not powerless. Doctors will spend the money, so perhaps
we do not need them to waste a great deal of time going along to troublesome things such as health and well-being boards. If I am not right, we should take out subsection (7).

Paul Burstow: The hon. Lady is right to say that she is not right. She is also right to say that there is no reason to accept the amendments. They are unnecessary. Had we done the exact opposite of what we have done in the Bill, I suspect that the hon. Lady would have argued that it was appalling that GP commissioning consortia would not have the flexibility and the opportunity to delegate—

Emily Thornberry: Will the hon. Gentleman give way?

Paul Burstow: Let me deal with some of the hon. Lady’s other points first.

Let me reiterate a point that is key to understanding this part of the Bill. It sets out the de minimis membership. It should not be seen by anyone who reads it, after the Bill is enacted, as providing a mandate, saying “These are the only people who can serve on this board” and no one else could possibly sit on it. What is absolutely clear from the White Paper consultation and discussions that we continue to have with colleagues in local government is that the flexibility that the Bill provides in relation to the arrangements for health and well-being boards is widely welcomed. Manchester city council and the Manchester adults health and well-being partnership have welcomed the “local freedom to determine the most appropriate membership reflecting the national statutory framework” that the Bill establishes. Norfolk county council say it supports our approach “which sees only a limited number of partners subject to a duty to cooperate” leaving top-tier authorities with the freedom and flexibility to decide any wider representation”.

The amendments detail bodies or organisations that it would be entirely appropriate to have on a health and well-being board, such as the police. Although my hon. Friend the Member for North Warwickshire has given reasons why that may not always be appropriate, the police certainly could be included. Government Members are not concerned about having an incomplete list, but about having one that can be interpreted not as a minimalist list, but one that excludes others and prevents them from being added to the board. That is why we have crafted the Bill as we have. It is about how best to ensure the maximum local flexibility and that the arrangements work well when it comes to the relationship between health and well-being boards and GP consortia.

Debbie Abrahams: Perhaps the Minister is not aware that a consequence of that minimalist approach is that some local authorities are deciding to designate their directors of public health at third tier level. In spite of what was advocated in the public health White Paper, which said that directors should be directly accountable to the chief executive, they are going to be at assistant director level—not directly accountable, therefore. Their budgets will be under the responsibility, perhaps, of directors of adults’ services, or children’s services. Those are the unintended consequences, and we are trying to show what needs to be firmed up in the Bill. Such points are very important.

Paul Burstow: They are points; they are important; but they are not points that relate to this set of amendments. The clause is about who sits on health and well-being boards and about who discharges the various functions that sit with such boards. We make it clear, as a de minimis requirement—not a minimalist requirement—that the director of public health should sit on the health and well-being board. What we are not trying to do, and the reason why we are resisting the Opposition amendments, is to construct an ever-lengthening list that increasingly excludes anyone who is not on it. That is why we are not having such a list.

Debbie Abrahams: I was just using that as an example. The Minister referred to a minimalist approach, and I gave an example of what happens when such an approach is used. Unfortunately, there will be unintended consequences that are directly counter to what the Government are trying to achieve. We all share the ambition to improve health and the quality of health services, and to reduce inequalities, but unfortunately, if the Government use a minimalist approach—I use that term again—that is what will happen. They will not achieve what they say they are seeking to achieve.

Paul Burstow: I reiterate that our position on the membership of health and well-being boards is not minimalist but de minimis. To make things absolutely clear to those who read our proceedings in future to interpret what we intended for the membership of the board, this is not about limiting the board’s ability to decide who else should be a member or limiting the local authority’s ability, when establishing the health and well-being boards, to think carefully about who should be involved. Interestingly, the early implementers of health and well-being boards are already exploring a variety of options. That is good and creative, and we should allow such practice rather than stifling it by imposing a long list.

Dr Poulter: Is that not exactly the point? The local needs in Eastbourne, for example, which involve looking after older people, are completely different from those in the constituency of the hon. Member for Easington, who is concerned about housing and the quality of housing stock. That is why we need flexibility in the arrangements, rather than being too prescriptive.

Paul Burstow: The hon. Gentleman is absolutely spot on, and he underlines the difference between the two sides of the Committee. I hope, none the less, that the purpose of this set of exchanges was to probe and to seek clarification and reassurance that although the Bill says that one healthwatch member should be on the board, that is a de minimis requirement and does not preclude the possibility of more. I hope that the hon. Member for Islington South and Finsbury will withdraw the amendment. If she does not, we will resist it.

Emily Thornberry: That was exactly the purpose, and I beg to ask leave to withdraw the amendment.
Clause 179

DUTY TO ENCOURAGE INTEGRATED WORKING

Emily Thornberry: I beg to move amendment 362, in clause 179, page 152, line 27, leave out ‘encourage’ and insert ‘ensure’.

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

Amendment 372, in clause 179, page 152, line 33, after ‘such’, insert ‘integrated’.

Amendment 363, in clause 179, page 152, line 34, leave out ‘encourage’ and insert ‘ensure’.

Amendment 364, in clause 179, page 152, line 37, leave out ‘encourage’ and insert ‘ensure’.

Emily Thornberry: I do not apologise for returning to a recurring theme. Yet again, we have a duty, relating to integrated working, and a weasal word. The duty is to encourage integrated working. The health and well-being boards seem to have very few functions, even though clause 179 comes under the heading “Health and Wellbeing Boards: functions”. What are the functions? They seem to be a “Duty to encourage integrated working”—there does not seem to be any other sub-heading. As it is such a recurring theme. Yet again, we have a duty, relating to integrated working, and a weasal word. The duty is to encourage integrated working. The health and well-being board will lie in its ability and capacity to create a culture of consensus across its membership. How do we know whether it is doing its job properly? How do we define “encourage” and how do we assess whether health and well-being boards have been successful? We must consider that the success of a health and well-being board will lie in its ability and capacity to create a culture of consensus across its membership. How do we know whether it is doing its job properly? How do we define “encourage” and how do we assess whether health and well-being boards have been successful?

Given that integrated working is such an important policy thrust and that the Government and the Opposition agree that we must have more integrated working and services, if the health and well-being board has a role, it is to bring all parties together and ensure that. Encouraging it is not sufficient. “Encourage” is a weasal word. Let us ensure integrated working. If health and well-being boards cannot ensure integrated working, we insert “ensure”.

Amendment 372 would change subsection (2), which provides for “arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services”, to read “integrated services”. The whole purpose of the clause is to ensure integrated working. Those are my arguments for the amendments. I will speak further on clause stand part, Mr Hancock.

4 pm

Paul Burstow: I start by reflecting on the fact that, for the best part of 13 years, the question of how we better deliver integrated services was one that I raised, in opposition, in relation to various pieces of legislation. Interestingly, I was always told that the duties provided through the NHS flexibilities would be sufficient. Of course, one reason why they have not proved sufficient is the absence of the right collaborative behaviours and working relationships in many parts of the country, which has got in the way of that happening. To drive that forward is one reason why we have crafted the Bill as we have, conceived the idea of a health and well-being board, and placed the duties in respect of joint strategic needs assessments and joint health and well-being strategies in the Bill in the way we have.

Let me address directly the suggestion from the hon. Member for Islington South and Finsbury that we should move from the language currently in the Bill, “encourage”, to “ensure”. The issue for us is the fear of the law of unintended consequences—unintended consequences that would follow from the amendment. There are areas of NHS activity—services that the NHS provides—in which integration with social care would never be appropriate. Specialist health services may have very little overlap, or indeed none, with social care, so requiring them to integrate would have very little benefit, and would in fact be an unnecessary burden placed on the NHS. We are trying to achieve a proportionate and appropriate framing of the legislation, requiring the health and well-being boards to drive forward integration where it is appropriate. That is what this is all about.

Emily Thornberry: Would the Minister be kind enough to clarify another aspect of this? How is “encourage” to be defined in the legislation? What criteria are envisaged as suitable to assess whether the duty to encourage has been met? Given that it is so important, how do we know whether a health and well-being board has been successful? We must consider that the success of a health and well-being board will lie in its ability and capacity to create a culture of consensus across its membership. How do we know whether it is doing its job properly? How do we define “encourage” and how do we assess whether health and well-being boards have been successful?

Paul Burstow: That question feels like the old style of top-down process targets which we became familiar, but to answer it, one way in which we would see evidence that integration was becoming more the norm would be the increased use of the NHS flexibilities that are available and which the Bill says the NHS commissioning board should promote actively to consortia. In addition, the responsibility for encouraging their use is placed on health and well-being boards. That would be a tangible and obvious way in which we could see clearly that commissioning was being undertaken in the form of lead commissioning, use of pooled budgets and so on. That is the intention behind the measure, and I think that it will provide opportunities for local authorities, in collaboration with the NHS, to join up services where that is appropriate, particularly in respect of care of older people but in other areas as well.

Jeremy Lefroy (Stafford) (Con): I draw the Minister’s attention to an example of such integrated working in my county of Staffordshire, where the local authority and the NHS are setting up a joint trust to provide precisely the kind of integrated working that is being discussed. Clearly, they have responded to encouragement and have not needed to be forced into doing it. That is a good model.
Paul Burstow: I certainly agree. I now want to draw attention to amendment 372. Again, I fear an unintended consequence of the amendment, because it would not do what the hon. Member for Islington South and Finsbury intends. An amended clause 179 would be limited to health and well-being boards providing advice, assistance or other support for the purpose of encouraging section 75 arrangements only in relation to already integrated services, rather than health and social care services. Inserting the word “integrated” would have that unintended and unfortunate consequence; it would narrow the scope of the clause. I hope, therefore, that the hon. Lady will not press that amendment or the others.

Finally, let me define the word “encourage”. In the absence of an express definition in the Bill, “encourage” will have its ordinary dictionary meaning, as in, for example, what will be done by boards by way of encouragement. In other words, I refer the hon. Lady to the Oxford English Dictionary for the necessary definition. I am sure she will be delighted about that because she has advanced the need for plain English in our legislation. I hope she will withdraw the amendment.

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

Amendment, by leave, withdrawn.

Amendments made: 444, in clause 179, page 152, line 43, at end insert—

“‘health service’ has the same meaning as in the National Health Service Act 2006;”.

Amendment 443, in clause 179, page 152, line 45, after ‘service’ insert ‘in England’.—(Paul Burstow.)

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

Mr Barron: I do not wish to delay the Committee for too long. I support the aims of the clause, but I want to try to find out a little more about how things are going to work on the ground.

Clearly, the current sub-structure within primary care trusts in respect of local pharmacies—I declare an interest as chair of the all-party pharmacy group—and of dentistry, and to some extent of ophthalmics as well, is pretty well known. I have had several meetings over the years with the local medical committee, whose influence, I assume, will be greatly strengthened because of how commissioning is going to change. It is going to be GP-led, but I wonder where the local pharmaceutical committee and dentist forum will sit in the new structure.

The clause is about integration, which I support. For far too long, the health service has delivered down stovepipes and has not looked at integrated care for individuals, particularly people with long-term conditions. Hopefully, the Bill will allow that to happen.

On the establishment of health and well-being boards, I accept entirely that they have the power to appoint such additional persons to be members of the board as they think appropriate. If we look at pharmacy, we see that all of us will have a very similar pattern, although some may not because of the differences between urban and rural areas. There are big players in my local pharmacy sector—the Co-op, Lloyds, Boots—but there are also regional players and some individuals as well.

I hope the Minister can reassure me, because I am worried that health and well-being boards might say, “We will have somebody who is representative of pharmacy on our board, so that they will be there all the time.” I accept that that is their choice and that it is probably a good thing, given the role that pharmacy plays now in the population’s health, looking after individuals who sometimes do not see doctors. But I am deeply worried that the big players could say, “We will put somebody on that. It will be at no cost.” They have the money to be able to take something to the table, potentially, whereas small, independent pharmacies, which are well known in their communities, may get their head turned away and decide, “We will have a pharmacies rep and that’s it.” Will the Minister give some assurance that that is unlikely to be the case?

I agree that we do not want to be too descriptive on these bodies, because flexibility is needed. I would hate to think that only the big players in the primary medical services were having the say in the community, rather than all the players. That will apply to some extent to dentistry, although it tends to be someone who has two or three practices as opposed to a big dental player like there are in cities, where companies are set up. I would like some reassurance that that will be heard and that we will not see local people—who are often described as members of the NHS family—who are effectively given a service by a contractor on occasion, having their nose shoved out of joint in being represented on local health and well-being boards.

Paul Burstow: I can reassure the right hon. Gentleman that it is not our intention to exclude the very people he has just talked about—it is not how the Bill is drafted. I can also add, for the interest and information of the Committee, that earlier today we considered, albeit briefly, clause 190, which deals with the transfer of the responsibility for pharmaceutical needs assessments to local authorities. In discharging that responsibility, local authorities will, of course, want to engage with local pharmaceutical committees to ensure that they have access to the relevant insight, experience and expertise. That will be one of the places they will go to in discharging that responsibility, among others. That will play an important part going forward in how the commissioning board discharges its responsibilities as well. I hope that I have been able to say enough to reassure the right hon. Gentleman, and with that I hope that the clause can stand part of the Bill.

Emily Thornberry: As I said earlier, the Government have talked a great deal about health and well-being boards and what a panacea they are going to be, yet when one looks at the legislation one realises how little their function will be. They have the duty to—waseal word—“encourage” integrated working, but little else. That is a great concern. I hear a certain amount of groaning from the Government side when I speak in these terms, but how many Government Members were watching television a few weeks ago at 9 o’clock on a Sunday morning, when the Secretary of State was being interviewed?

The Minister of State, Department of Health (Mr Simon Burns): He was very good.
Emily Thornberry: He said some things of interest. This is another example of how over-excited the Government Front Benchers can be, how far they can fly in flights of fancy, and how far they can be from the ball sometimes. I understood, from what the Secretary of State said, that health and well-being boards would be allowed to agree commissioning plans. That was what was reported in the press. When I look at the Bill, I cannot see anything that says that health and well-being boards will sign off commissioning plans of GP consortia—far from it. The public need to understand how little power health and well-being boards have, compared with GP consortia and how little accountability there is of GP consortia compared with the supposed accountability of health and well-being boards.

The Government response to the White Paper makes it clear that the Government have considered whether health and well-being boards should have formal decision-making powers over GP consortia on their commissioning plan. I read that with some interest. I refer Government Members to page 98 of the Department of Health’s response to the White Paper, in the chapter titled “Local democratic legitimacy”—they cannot stop themselves can they?—which has an interesting passage that states:

“Sutton and Merton PCT reflected the views of many respondents when seeking clarity on what ‘health and wellbeing boards are accountable for and how that accountability sits with clinical commissioning consortia’s accountability to the NHS Commissioning Board.’”

I am sure that the Minister knows the argument well. The answer to that was:

“Formal approval rights for health and wellbeing boards would put them in a more powerful position than the NHS Commissioning Board, to whom the consortia are primarily accountable.”

4.15 pm

We have given double the amount of money that we spend on defence to GP consortia, and they are not primarily accountable to health and well-being boards. The Government have said it themselves. GP consortia are primarily accountable to the NHS commissioning board, who are the faceless bureaucrats from Whitehall and are supposed to be the enemy of the Minister. Nevertheless, he has said time and time again that he wants to shine the light of democracy on all corners of the national health service and other phrases of that nature—I am afraid that I do not know them off the top of my head. The point is that if the Bill is to give health and well-being boards any power, such as signing off the commissioning plans of GP consortia, clause 179 is the time to do it. However, in many ways, it is an empty clause, which is such a shame, because it is a missed opportunity. We want to focus on the many things that are wrong with the Bill, and this provision is certainly wrong.

Another section in the Department of Health’s response to the White Paper states:

“The Government is also clear that it cannot grant authority without responsibility: it would contravene the principles of financial accountability to give local authorities the ability to make NHS commissioning decisions that could commit additional expenditure from GP consortia, without local authorities having to take responsibility for that expenditure.”

That, however, is the whole point. I thought that the whole point was that local people would start taking responsibility for the NHS. It was going to be accountable. We were going to be able to work in partnership. There was going to be “no decision made about me without me” and all the other associated flights of fancy that we have heard from Government Members. When it comes down to it, however, they are exposed when they say that GP consortia will be primarily accountable to the NHS commissioning board and not to health and well-being boards, which is why health and well-being boards cannot sign off the commissioning plans. There we are. That is why the clause is as short, weak and disappointing as it is.

Question put and agreed to.

Clause 179, as amended, accordingly ordered to stand part of the Bill.

Clause 180

OTHER FUNCTIONS OF HEALTH AND WELLBEING BOARDS

Emily Thornberry: I beg to move amendment 365, in clause 180, page 153, line 15, at end insert

‘a Health and Wellbeing Board preparing to give an opinion in respect of this section shall have regard to the views of any relevant overview and scrutiny committee on whether the authority is discharging its duty under section 116B (duty to have regard to assessments and strategies).’

The amendment speaks for itself.

Paul Burstow: The amendment would blur the separation between the executive and scrutiny functions, which is an issue that was recognised as important not only by the Government in responding to the consultation, but also in the county councils network’s submission, which stated:

“It is not appropriate for Health and Wellbeing Boards to have both the executive and scrutiny functions.”

The amendment has the effect of reversing that and making a link that would be unhelpful to local authorities in properly discharging their separate responsibilities for scrutinising. The hon. Lady is worried in case concerns arise over joint strategic needs assessments—not having proper regard for them with regard to commissioning health or social care—but the scrutiny committee can look into such matters. It can call colleagues from within the local authority; it can call the relevant people from GP commissioning consortia to discuss the matter; and it can make reports. That is the strength and value, which the hon. Lady herself has identified earlier in the Committee, of scrutiny committees. It is why we want to maintain it and why we will resist the amendment.

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

Amendment, by leave, withdrawn.

Clause 180 ordered to stand part of the Bill.

Clause 181

PARTICIPATION OF NHS COMMISSIONING BOARD

Amendments made: 445, in clause 181, page 153, line 32, leave out ‘authority’s area’ and insert ‘area of the authority that established the Health and Wellbeing Board’.
Amendment 446, in clause 181, page 153, line 42, at end insert—
"‘health service’ has the same meaning as in the National Health Service Act 2006.”.—(Paul Burstow.)

Clause 181, as amended, ordered to stand part of the Bill.

Clause 182 ordered to stand part of the Bill.

Clause 183

SUPPLY OF INFORMATION TO HEALTH AND WELLBEING BOARDS

Amendments made: 447, in clause 183, page 154, line 14, leave out ‘(9)’ and insert ‘(8)’.

Amendment 448, in clause 183, page 154, line 16, leave out ‘(9)’ and insert ‘(8)’.—(Paul Burstow.)

Clause 183, as amended, ordered to stand part of the Bill.

Clause 185 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned.

—(Stephen Crabb.)

4.24 pm

Adjourned till Tuesday 15 March at half-past Ten o’clock.