Public Bill Committee

HEALTH AND SOCIAL CARE
(RE-COMMITTED) BILL

Fourth Sitting
Thursday 30 June 2011
(Afternoon)

CONTENTS
CLAUSE 1 disagreed to.
CLauses 2 to 4 agreed to.
CLAUSE 5 agreed to, with amendments.
SCHEDULE 1 agreed to.
CLAUSE 6 agreed to.
CLauses 9 to 11 agreed to, one with amendments.
Adjourned till Tuesday 5 July at half-past Ten o’clock.
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Monday 4 July 2011

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

**Chairs:** †MR ROGER GALE, MR MIKE HANCOCK, MR JIM HOOD, DR WILLIAM MCCREA

† 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)
† O’Donnell, Fiona (*East Lothian*) (Lab)
† Poulter, Dr Daniel (*Central Suffolk and North Ipswich*) (Con)
† Pugh, John (*Southport*) (LD)
† Shannon, Jim (*Strangford*) (DUP)
† Smith, Owen (*Pontypridd*) (Lab)
† Soubry, Anna (*Broxtowe*) (Con)
† Sturdy, Julian (*York Outer*) (Con)
† Thornberry, Emily (*Islington South and Finsbury*) (Lab)
† Turner, Karl (*Kingston upon Hull East*) (Lab)
† Wilson, Phil (*Sedgefield*) (Lab)

Sarah Davies, Mark Etherton, *Committee Clerks*

† attended the Committee
The Chair: Good afternoon, ladies and gentlemen. The termination time for the groups of amendments and clauses under discussion today is 6 o'clock. I shall be minded to suspend the Committee for about 20 minutes at 4 o'clock, unless it becomes apparent by then that we are within 15 or 20 minutes of completing the whole sitting, in which case we will sit right through. However, I do not believe that it is right to ask the staff to sit for more than three hours without a break. I hope that that will be acceptable.

Clause 1

THE SECRETARY OF STATE AND THE COMPREHENSIVE HEALTH SERVICE

Amendment proposed (this day): 1, in clause 1, page 2, line 4, leave out from ‘(b)’ to ‘in’ in line 6 and insert ‘must provide or secure the provision of services.’—(Liz Kendall.)

Question again proposed. That the amendment be made.

The Chair: I remind the Committee that with this it will be convenient to discuss the following:

Clause stand part.

Amendment 227, in clause 3, page 3, line 5, leave out from ‘must’ to ‘reduce’.

Government amendments 55 and 56.

Government new clause 1—Secretary of State’s duty to promote comprehensive health service.

Government new clause 2—Secretary of State’s duty to keep health service functions under review.

Emily Thornberry (Islington South and Finsbury) (Lab): Before lunch, I was speaking to new clause 2 and amendment 227. I have finished the main points that I wanted to make. Some of my hon. Friends may wish to say more, particularly on the Secretary of State’s duty to reduce inequalities under clause 3, but in the interests of brevity, I refer whomever might be reading the report of this debate to the comments that I made in previous debates on equalities.

Having prayed in aid the previous debates, I have some additional points to make. There is without doubt huge concern about the Secretary of State’s duty in relation to the health service—indeed, it is one of the focuses of concern. I believe that hon. Members on both sides of the Committee have been contacted by an organisation that has been collecting a massive number of signatures—now more than 400,000—to a petition. The first thing to which it refers, as I believe hon. Members know because they have all received a number of e-mails about this, is the concern about the ongoing duty of the Secretary of State in relation to the health service. In summary, if a change needs to be made to the original Act—the National Health Service Act 2006—in relation to the Secretary of State’s duties, we need a clear reason why, and that reason needs to be one that we can explain to the 400,000 or so people who have expressed concern through the online petition.

This cannot be brushed under the carpet. It is a matter of trust. It is hugely important and has ramifications throughout the Bill. As I have already said, we regret hugely the fact that we are unable to debate the entire Bill in the light of the ongoing duty of the Secretary of State, but I have made the point and I do not intend to labour it; nor do I think that I would be able to improve it by simple repetition. On amendment 227 and the duty to reduce inequalities, let us make the measure clear and straightforward and simply give the Secretary of State a duty to reduce inequalities. If the Bill does what the Government say it will, that should not be a problem.

On new clause 2, I have raised the appointment of the board by the Secretary of State, which is not within the Nolan rules. I want confirmation of whether there are any Government amendments relating to the appointment of members of the boards of all the other bodies listed in the new clause, and whether they will be appointed under the Nolan rules. Obviously, if the question arises of why they are appointed under the Nolan rules and the national commissioning board is not. Perhaps the Minister of State could explain that to us.

Grahame M. Morris: I am grateful, Mr Gale. The Minister is looking perplexed, but I did indicate earlier that I wished to speak.

The Minister of State, Department of Health (Mr Simon Burns): I look forward to hearing you.

Grahame M. Morris: Other hon. Members have highlighted in this debate and on previous occasions, not least in the initial exchanges between my hon. Friend the Member for Oldham East and Saddleworth and the Secretary of State in the initial consideration of the Bill, the dubious relationship between what the Government say and what the Bill actually does. During his first attendance at an evidence session, the right hon. Gentleman was asked by my hon. Friend if he could explain why he decided to repeal the duty placed on the Secretary of State to provide a comprehensive health service. His reply was,
"I have not… Clause 1 effectively reproduces the 1948 duty on the Secretary of State and it applies it to the other organisations through the rest of the Bill."

He went on to say,

"It is in the original language. It is reproduced the same way."—[Official Report, Health and Social Care Public Bill Committee, 10 February 2011; c. 166, Q402-04.]

The duty of the Secretary of State under the National Health Service Act 2006, repeating the language of section 1 of the National Health Service 1946,(119,216),(964,986) is, for the purpose of promotion of a comprehensive health service, to

"provide or secure the provision of services in accordance with this Act".

Clause 1 of the original Bill replaced that duty—the point made by my hon. Friend. Friend that the Secretary of State sought to push to one side. It provided instead that the Secretary of State

"in exercising functions in relation to a body mentioned in subsection (2A), must act with a view to securing the provision of services for the purposes of the health service in accordance with this Act."

For the information of the Committee, new subsection (2A) lists the NHS commissioning board, the commissioning consortia, which we are now calling commissioning groups, and local health authorities in respect of their public health functions.

Our concerns about the clause, voiced in the original Committee, were that the Secretary of State sought to reduce the accountability of his role in the delivery of health services. That was vigorously denied. The recommendations of the NHS Future Forum are clear:

"The NHS should be freed from day-to-day political interference but the Secretary of State must remain ultimately accountable for the National Health Service. The Bill should be amended to make this clear."

The clause establishes an NHS commissioning board, the commissioning boards as well as passes responsibilities to local authorities for public health. The importance of the clause is the way in which the Secretary of State’s responsibilities would change. He would lose his current duty to provide or secure the provision of services for the purpose of the health service. Instead, the new duty on the Secretary of State is the simple promotion of the comprehensive health service, which is an important and fundamental difference of approach. [Interruption.] The hon. Member for Southport says it is the same thing, but in fact it is quite a fundamental difference, placing a direct responsibility or duty on the Secretary of State, which is what the Future Forum indicated the Government should do.

Fiona O’Donnell (East Lothian) (Lab): My hon. Friend and I share the experience of being new Members, which is perhaps why we are so perplexed. Does he share my concern that the Government are seeking to amend a piece of legislation while saying that that will make no difference to it?

Grahame M. Morris: That is spot on the heart of the matter. Time and again, our interpretation has been different and Ministers have said that we misunderstood the intent, but the NHS Future Forum, other organisations and, indeed, the Liberal Democrats have indicated that this is a major concern. It is, therefore, reasonable to highlight it.

John Pugh (Southport) (LD): I might be wrong, but when the hon. Gentleman referred to the Bill as previously drafted, I think he said that the Government’s intention was to put in the clause only a reference to “promoting”, yet new clause 1 uses the verb “secure” twice. The hon. Gentleman should speak to the new clause, rather than to a clause that will be altered however we vote.

Grahame M. Morris: If the hon. Gentleman will bear with me, I am seeking to expose or identify the original arguments made by the Ministers. They are now moving away from that position and accepting the arguments made by Opposition members of the Committee, who, to be fair, were the first to discover that the emperor had no clothes. It seems to have been generally accepted that that is the case. A significant bone of contention is that Opposition members of the Committee believe that an elected official—a Minister—should be accountable for the performance of the NHS.

Nick de Bois (Enfield North) (Con): On a point of order, Mr Gale. Perhaps you can give me some guidance. We have tight time limits and want to give due scrutiny to the Bill, so is it right for prepared texts to be used when speaking?

The Chair: That is not strictly a point of order, but I will seek to answer it. The Speaker has indicated, and the traditions of the House suggest, that wherever possible Members should speak from notes rather than from prepared speeches and that they should most certainly not read speeches prepared by any outside organisation. However, I have no indication at present that that is what is taking place.

Grahame M. Morris: I am grateful to you, Mr Gale. Many of the issues are highly technical. I am not absolutely familiar with the detail of the NHS Future Forum report, so I am afraid that I need to refer to a written text. It is important that the issues are placed accurately on the record.

Karl Turner (Kingston upon Hull East) (Lab): On a point of order, Mr Gale. I find it outrageous that Government Back Benchers should make such points. I have spent many days and weeks on this Committee, and have heard the Minister read prepared speeches into the record, with no criticism from either side of the Committee. I know that my hon. Friend the Member for Easington is not reading a prepared speech, but even if he was, it would be his own work, not that of an outside body.

The Chair: I listened very carefully to the question that was put to me, and I answered it. I do not recall any suggestion being made, and I indicated that I had not seen any evidence to suggest, that the hon. Member for Easington was reading a prepared speech. I answered the question that I was asked. I have ruled on the matter. I think that we had better leave it there.

Grahame M. Morris: I am grateful to you, Mr Gale. We have identified a contentious point. An elected official—a Minister in this case—should be held accountable for the performance of the NHS, and the Secretary of
State should exercise responsibility for the provision of high-quality health care in a comprehensive national health service.

Until now, the Secretary of State has been directly responsible for securing the provision of all health services, as set out in the National Health Service Act 2006. If my memory serves me correctly, the disagreement with Opposition members of the Committee was based on the difference, which the hon. Member for Southport has just indicated, between whether the Government were delegating or conferring on other bodies the specific duties that were previously placed on the Secretary of State—essentially, delegating his responsibilities.

1.15 pm

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): I am following the hon. Gentleman’s argument and the case that he is making. The hon. Member for Islington South and Finsbury made the point that it is important for the Secretary of State to have a duty to reduce health care inequalities. Is the hon. Gentleman disappointed that such a duty was not put into legislation by the previous Government during their 13 years in power?

Grahame M. Morris: Mr Gale, I will confine my remarks to the issue in hand. I have some specific points in relation to health inequalities, but to move things along a little more speedily, I will not refer to them.

The Secretary of State should have a responsibility for a truly comprehensive national health service, as was previously the case.

Mr Burns: It still is.

Grahame M. Morris: The Minister says that, but our concern is that under the original Bill, those functions were delegated to other bodies—the NHS commissioning board, local commissioning groups and other organisations. The NHS Future Forum recommended that that was not an appropriate course of action, which is a view that was first highlighted by the Labour party.

Mr Burns: I am not sure whether the hon. Gentleman fully appreciated what the Future Forum said about this. Let me help him by reading what it said in its “Patient Involvement and Public Accountability” report. It says:

“We have heard concern from various quarters that the Secretary of State for Health will no longer have a responsibility or duty in respect of promoting a comprehensive health care service... We understand that this is not in fact the case as far as the proposed Bill is concerned.”

It continues:

“The Secretary of State will remain ultimately responsible for improving the health of the nation”.

Grahame M. Morris: I am aware of what the Future Forum said. Indeed, we took evidence from representatives of the forum and questioned them at greater length in the Select Committee on Health, but I question some of the responses of Professor Steve Field on the basis on which he arrives at some of his contentions, not least in relation to taking independent legal advice. Under questioning, Professor Field was asked whether European competition law applied and whether the Future Forum had taken independent legal advice. His response was that the only legal advice that it had taken was from the solicitors from the Department for Health. I can cite other examples of inconsistencies in Professor Field’s evidence to this Committee and the Health Committee.

Emily Thornberry: I do not know whether my hon. Friend is aware that an application was made by Opposition Members to have an expert in international competition law called to give evidence, but that was voted down by the Government.

Grahame M. Morris: Yes, I was aware of that. It is disgraceful that the Government were not prepared to clarify this issue and have some independent legal advice.

John Pugh: I am a little concerned about the hon. Gentleman’s comments about the apparent inconsistencies in Professor Field’s evidence. Are you accusing him of incompetence or of misleading us? What exactly are you saying about Professor Field?

Dan Byles (North Warwickshire) (Con): I am following the hon. Gentleman’s argument. Professor Field was asked whether European competition law applied and whether the Future Forum had taken independent legal advice. His response was that the only legal advice that it had taken was from the solicitors from the Department for Health. I can cite other examples of inconsistencies in Professor Field’s evidence to this Committee and the Health Committee.

The Chair: Order. The hon. Gentleman must address his remarks through the Chair. I am not commenting upon it at all.

Dan Byles: I apologise, Mr Gale.

Grahame M. Morris: I am grateful to the hon. Gentleman for raising that because my observations are based upon fact. It calls into question the reliability of Professor Field’s evidence.

Fiona O’Donnell: Will my hon. Friend give way?

Grahame M. Morris: I will in a moment. When Professor Field came before the Health Committee in his capacity as one of the leaders of the Future Forum, he was asked about its role and independence. He was asked whether the Future Forum had taken representations from the trade unions and the staff involved in the health service as legitimate stakeholders in the exercise and whether they had raised with him their concerns about the fragmentation of the service caused by implementation of the proposals and the threats to national bargaining on pay and conditions. He replied that no such representations had been received, yet the written evidence that this Committee received on Tuesday from the trade union representatives Professor Field consulted states that they had made that very point. To my mind and that of many other people, that calls into question the reliability of Professor Field’s evidence. I do not know if he is a reliable witness on that basis. He said one thing to the Select Committee and something...
completely different to the Bill Committee, which was directly contradicted by a stakeholder group with whom he had had dealings. That is a simple point.

Fiona O’Donnell: I am sure my hon. Friend will remember that on Tuesday Professor Field also acknowledged that he had omitted caps on private patients in foundation trust hospitals from the report.

Grahame M. Morris: That is a relevant point when the whole basis of this Committee’s deliberations is the recommendations of the Future Forum report. Many of the issues that have been raised have not been taken up either as clauses referred back or as Government amendments. There is an issue of consistency and fairness in this.

Returning to the clause stand part debate, we were dealing with delegating or conferring duties from the Secretary of State and on to other bodies. It was the Minister or the Secretary of State, I think, who in their evidence coined the expression that when the bedpan is dropped the noise should be heard in Whitehall.

Mr Burns: I rise to help the hon. Gentleman. That is actually a quote from his hero, Nye Bevan.

Owen Smith (Pontypridd) (Lab): He is my great hero and the bedpan in question was in Tredegar.

Grahame M. Morris: Anyway, it was referred to in this Committee as a way of saying that the Secretary of State should be in tune with problems and issues in the health service.

I accept that, under current arrangements, it is only possible for the Secretary of State to do that. My hon. Friend the Member for Islington South and Finsbury made an excellent point this morning about the Secretary of State for Defence not being responsible for equipping individual soldiers with items of kit—army boots were given as an example—but is ultimately responsible for ensuring that the Army is properly equipped and able to deal with the tasks that it faces. Similarly, I am not suggesting that the Secretary of State should be hands-on and micro-manage, as Government Members often say, every single issue. I accept that he cannot do that because, at the moment, those functions are exercised through structures such as the strategic health authorities and primary care trusts, which will not exist under the new arrangements. It is therefore all the more important that the duty is conferred upon an accountable individual. Despite the delegation under the current arrangements, it is quite clear that the SHAs and the PCTs remain under the duty of care of the Secretary of State, who—this is the key point—remains accountable to Parliament for the provision of services.

Despite the Secretary of State’s denials to the Committee, the Opposition have been clear from the very start that the duties outlined in the Bill would no longer be delegated and that direct responsibility would be taken away from the Secretary of State through the modified clause 1. It is also clear that direct responsibility for securing the provision of health services would be conferred on the bodies that I referred to earlier—the NHS commissioning board and the local commissioning groups—and that provision is set out explicitly in clauses 5 and 6. We will deal with those later, so I will not say any more about that.

Government new clause 1 changes the role of the Secretary of State, but it is disingenuous to pretend that the original duty on the Secretary of State has been fully applied. As I have said, these concerns have been raised by several organisations and, indeed, by the Liberal Democrats as one of the three key issues. The hon. Member for Southport mentioned the number of e-mails that he has received, and I have received a similar number, including some that also highlighted the duties that are to be placed on the Secretary of State. New clause 1 reiterates the “duty to promote comprehensive health services” and, although it uses the original language, it adds a key point:

“For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.”

We have an ever more complicated set of intertwining and cross-cutting stipulations about who is responsible for what.

I found the grouping of amendments slightly confusing this morning, Mr Gale, but I now appreciate that we are dealing with similar themes. I shall refer briefly to clause 5 because it covers some of the same elements. That clause creates a new section 1D of the 2006 Act, whose wording is similar to clause 1, giving the NHS commissioning board its general duty. This group of amendments also affects clause 5, but new section 1D(2) remains, meaning that the board will be concurrently bound with the Secretary of State to the duty in section 1(1) of the 2006 Act, which is to promote comprehensive health services—except for public health, which is going to local government. However, where the duty on the Secretary of State is to act “with a view to securing the provision of services”, that has now been changed, and it remains applicable to the board.

Government amendment 55 outlines the board’s duty to “exercise the functions conferred upon it by this Act in relation to the commissioning consortia so as to secure that services are provided for those purposes in accordance with this Act.” However, the changes to section 3 of the 2006 Act, which is the successor to section 3 of the 1946 Act, remain intact, and it currently states that the Secretary of State “must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements”. For the Committee’s information, those requirements are:

“(a) hospital accommodation,
(b) other accommodation for the purpose of any service provided under this Act,
(c) medical, dental, ophthalmic, nursing and ambulance services,
(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,
(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,
(f) such other services or facilities as are required for the diagnosis and treatment of illness.”
1.30 pm

As for the issue of consistency between clause 1 and some of the other clauses where similar changes would make sense, clause 9, which we will come to later, replaces the duty on the Secretary of State that we have just been talking about with a duty on the commissioning consortium. As the Minister kindly pointed out this morning, we have changed the nomenclature, so that the commissioning consortium “must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility”.

Again, on ensuring consistency and a similar approach throughout all the clauses, clause 10 will add to the 2006 Act new section 3A, which provides that consortia “may arrange for the provision of such services”—

The Chair: Order. When the hon. Gentleman got to clause 5, he was referring to Government amendments, which was fine and in order. Clauses 9 and 10 will be considered through other amendments, so I trust that he will not seek to speak on the same subject when we reach those clauses.

Grahame M. Morris: I accept that, Mr Gale. Overall, the Government amendments go some way towards restoring the duty on the Secretary of State. I acknowledge that, but I regret that the Government were not prepared to admit that initially when Opposition Members made exactly the same arguments in the original Bill Committee. As I say, the Government's amendments go some way towards restoring the duty on the Secretary of State, and apply it to the commissioning board with regard to securing the provision of services, but only in so far as it is exercising functions conferred by the Bill. Indeed, the Bill as amended by clause 1 gives the commissioning board a duty to ensure that services are provided through its functions in relation to the local consortia, but specific services are left to local determination.

Despite the Government's amendments, the Bill as a whole still considerably weakens the Secretary of State's duties and places the most significant weight of duty at the national level, with the NHS commissioning board. If there is not an accountable individual—a politician in the form of the Secretary of State—and those duties are exercised by the national NHS commissioning board, Opposition Members will have concerns about accountability issues. We have already been told that we should refer to clinical commissioning groups, rather than commissioning consortia. The legal framework places the bulk of power with clinical commissioning groups, which will be able to determine what services are provided on the NHS to a far greater extent than local commissioners ever could under existing arrangements.

Mr Burns: It has been extremely useful to be able to talk this morning and this afternoon about the Secretary of State's duty to promote a comprehensive health service. That is an important point, and I am pleased to have the chance to explain to the Committee the changes that we have made to clause 1, and the reasons for the changes, particularly in clause 1(2).

The Government's amendments respond to the Future Forum's recommendation that “the Secretary of State's responsibility for promoting a comprehensive health service should be made clearer to the public in order to allay any concerns and remove any confusion.”

The Future Forum was right to point out that the drafting of the Bill is not clear enough, and we are amending the wording to remove any doubt that the Secretary of State remains ultimately accountable for the NHS.

We intend clause 1 not to stand part of the Bill, and in its place we propose new clause 1. Unlike clause 1, new clause 1 sets out section 1 of the 2006 Act, as revised, in its entirety. Section 1(1) of the 2006 Act remains unchanged since the founding National Health Service Act 1946. The provision is identical to the wording in the 2006 Act, including the words:

“The Secretary of State must continue the promotion in England of a comprehensive health service”.

That duty has stood the test of time for more than 60 years. It is the core duty that underpins the NHS. It has never changed. We are not going to change it, and we are amending the Bill to make that crystal clear. It is that duty to which we are referring when we say that the core duty on the Secretary of State remains the same.

Owen Smith Will the right hon. Gentleman give way?

Mr Burns: I shall make a little more progress first. Section 1(3) of the 2006 Act would also remain unchanged. The provision reproduced in the Bill is almost identical to the provision set out in the 2006 Act, which derives from the founding NHS Act of 1946. Services will continue to be free at the point of use where they are now.

Fiona O'Donnell: Will the right hon. Gentleman give way?

Mr Burns: I will finish this point first and then give way to the hon. Member for Pontypridd.

The only difference in wording is the reference to services that are part of the health service, rather than services that the Secretary of State provides or secures. That ensures that the prohibition on charging applies to the services commissioned by the board or clinical commissioning groups. I reassure the hon. Member for Oldham East and Saddleworth that it includes all free services that form part of the health service, so it covers services commissioned by the board, clinical commissioning groups and, in relation to public health, local authorities. As set out in the Government response to the Future Forum report, we have committed to not introducing any new charges.

Owen Smith: The right hon. Gentleman will forgive me if I misheard him—perhaps he was going on to explain this—but did he not say a moment ago that clause 1 is unchanged? If that is the case, is that not effectively what the Secretary of State said, in slightly different language, in his oral response to the Future Forum? Is the reality not, as I hope the Minister will go on to explain, that clause 1(1) and clause 1(3) are the same as in the 2006 Act, but clause 1(2) is fundamentally different? Therefore, is it not slightly disingenuous of the Government to suggest that they are replicating the 2006 Act? In fact, there are slightly different words,
although the spirit of what is proposed is the same. The NHS will be placed at one step’s remove from the Minister.

**Mr Burns:** What I said to the Committee was basically an echo of the first part of what the hon. Gentleman has said. I said that section 1(1) of the 2006 Act remains unchanged, and that section 1(3) remains unchanged, and I then explained what the change to clause 1(2) was and why.

The Bill originally replaced the Secretary of State’s duty in section 1(2) to
“provide or secure the provision of services”—a duty to
“act with a view to securing the provision of services”.
That was for two main reasons: first, because the Secretary of State—that is, the Department of Health—does not in practice provide or commission services, because that function is delegated to SHAs and PCTs; and, secondly, because commissioning functions will in future be conferred directly on a dedicated NHS commissioning board and clinical commissioning groups, acting subject to the mandate and the standing rules.

Hon. Members will, of course, be familiar with the fact that the mandate is issued to the commissioning board by the Secretary of State. That was wrongly interpreted by some as a reduction in Ministers’ responsibility. We have therefore amended the Bill to make it clear that the Secretary of State will retain ultimate accountability for securing the provision of services. In future, in relation to the NHS, the Secretary of State, rather than delegating to NHS bodies the duty to provide or arrange services directly, will exercise his duty through his relationship with the NHS bodies. For example, he will set the mandate for the NHS commissioning board, report annually on the performance of the comprehensive health service, and hold the arm’s length bodies, such as the NHS commissioning board and the regulators, to account.

In reply to the question from the Member for Islington South and Finsbury, the Secretary of State has powers to appoint and remove the chair and non-executive directors in each of the arm’s length bodies listed in new clause 2. He will have extensive powers to intervene in the event of significant failure. I will explain that in further detail for the benefit of the Committee.

**Emily Thornberry:** The right hon. Gentleman says that he has answered my question. Perhaps I was not sufficiently clear. My question was about the appointment of the chair and non-executive directors in relation to all the arm’s length bodies, not their removal. Will he help us by saying whether, avoiding the Nolan principles, the Secretary of State will have the power to appoint the boards of all the arm’s length bodies?

**Mr Burns:** I am sorry if the hon. Lady thinks that. I was responding to a point that I thought she made before lunch. I was going to come on to her subsequent point about the Nolan principles, but I will deal with it now, as she has intervened. The Nolan principles and the code of practice of the Office of the Commissioner for Public Appointments will apply to all ministerial appointments to the arm’s length bodies. That includes the chairs and the non-executives of Monitor, the CQC, the National Institute for Health and Clinical Excellence, the Information Centre, and the NHS board.

The Secretary of State will also have extensive powers to intervene in the event of significant failure. As I said, I will explain that in detail for the benefit of the Committee because I think it would be useful given some of the comments that we have listened to during this debate.

The Secretary of State has the power, under proposed new section 13W in clause 19, to intervene if the board fails to discharge its functions properly or at all. In the first instance, he could direct the board on how it carries out its functions. If it fails to comply with those directions, the Secretary of State could either discharge the function himself, or make arrangements for another body to do so on his behalf. Clearly, that would be a last resort. The aim would always be to ensure that the NHS commissioning board carries out its functions in the way that Parliament intends. That would not give the Secretary of State a power to provide services. The board will have two main functions—first, a function to commission certain services and, secondly, functions in relation to clinical commissioning groups, such as allocating funding, which it must exercise so as to secure the provision of services. The Secretary of State could not use his intervention powers to exercise a function that the board does not have. I hope that the Committee now understands that the Secretary of State has all the necessary and appropriate functions in the Bill to enable him to secure the provision of services.

**John Pugh:** Does it not follow from what the Minister says about the step-in powers that the Secretary of State has a clear role in ensuring provision when it is otherwise deficient? He would thus retain the central role, which I think people want him to have, in provision without allowing a lot of commissioning to take place on a local and regional basis.

**Mr Burns:** I did not hear the last bit.

**John Pugh:** Will the Secretary of State retain a role in provision, and ensure that provision takes place when commissioners fail to provide a comprehensive health service?

1.45 pm

**Mr Burns:** I hope I can reassure the hon. Gentleman by saying yes, the Secretary of State will.

**Emily Thornberry:** I still do not understand the Minister’s argument; let me make that clear. As section 1(2) of the National Health Service Act 2006 states: “The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act.” The Minister does not want that in the clause, so he has changed it, but I do not understand why. Under the previous regime, if I understand what the Minister has said, the Secretary of State had a duty to provide, and did so by delegating powers to others. Is the Minister saying that that will not happen now—that the Secretary of State will not have a duty to provide, and will not do that by delegating powers to others?
Mr Burns: Opposition Members have some understanding of the position, but I will go into slightly more detail, in the hope that that will clarify the situation. As there is a misunderstanding about the duty to provide services, I will talk hon. Members through it.

Providers have the function of providing services. Commissioners have duties to commission services from providers. The Secretary of State and the national bodies have a duty to ensure that those activities take place as they should. I am sure that Opposition Members do not realistically intend the Secretary of State personally to provide health services, but that is what reinstating the duty to provide would mean, as set out in the relevant amendments. The critical thing is that mechanisms are in place to ensure that services are commissioned and that providers provide those services, and that there are mechanisms to circumvent problems and ensure that services are provided. The Secretary of State, in extreme cases, has the ultimate sanction to ensure that that continues if there is a problem.

Currently, the Secretary of State’s duty to provide services can be fulfilled with the benefit of two additional provisions, which are the power in section 12 of the 2006 Act to commission services instead of providing them directly, and the power in section 7 of that Act to delegate functions to SHAs and PCTs. The Secretary of State takes advantage of both those provisions, so that PCTs commission services from providers on his behalf. That is the existing system, which no one seems to object to.

The proposed new architecture sets out far more clearly where responsibility should lie, rather than relying on a system of delegation. I hope that helps to reassure the Opposition Front-Bench team, although I suspect that it will not.

Emily Thornberry: This is the nub of the difference. Previously, health providers commissioned on behalf of the Secretary of State—no one expected him to go and peel someone’s bunions for them. Other people did that on his behalf, but he was ultimately responsible, and he had political accountability. We are no further forward than when the Bill first appeared in the original Bill Committee. We have the Secretary of State setting up architecture and saying, “Right, I’m the Secretary of State, but you’re the commissioners, so I’m giving you that job. It’s nothing to do with me, guv. You go and commission. If you do it wrong, I may be able to sack you.”

Mr Burns: Not “may be”; will be.

Emily Thornberry: “I will be able to”, then. There will be something in the way, however. You are putting obstacles in the way of the Secretary of State’s direct accountability to the public, through Members of Parliament, and you are clinging on to—sorry, obviously you are not, Mr Gale. The Secretary of State and the Department are clinging on to a change that people fundamentally do not want. Some 400,000 people have signed a petition urging the Government to drop the reforms. All that the Minister has done is confirm that the changes made are simply cosmetic; the fundamental point remains the same. Clause 1(2) addresses the power of the Secretary of State, and if you will not change that, you are clearly not bona fide on that point.

Mr Burns: I am sure that you have nothing to do with it, Mr Gale, but to respond to the hon. Lady, this is the nub of the problem. After all our debates, and after all that she has presumably studied and read, the hon. Lady does not understand the ethos behind our modernisation of the NHS—or seeks to misunderstand it in public. The principle is this. We said before we came into power that we did not want political interference and micro-management in the day-to-day running of the NHS, although we did want high-quality services based on the core principles of the NHS.

The Secretary of State will provide a mandate to a national commissioning board to drive the commissioning of care through clinical commissioning groups and, in certain cases, through direct commissioning. However, as we keep saying, the Secretary of State will still be responsible for the health service, and even the Future Forum. When Opposition Members like what the forum has said, they cite it with admiration, saying how wise the forum is, but if it says things that do not agree with their prejudices, they say that it is wrong, or that it has not consulted or whatever.

If it is any help to him, I correct the hon. Member for Easington. If he would care to read the Future Forum’s report, he will see that on page 37 it says that among the more than 250 national stakeholder organisations that it consulted at its many meetings were the unions, although the hon. Gentleman did not seem to think so.

Grahame M. Morris rose—

Mr Burns: I regret saying that, because the hon. Gentleman wishes to intervene. First, however, may I finish answering the hon. Member for Islington South and Finsbury?

The hon. Lady constantly repeated the mantra that the Secretary of State cannot be held to account by Parliament. That is just not true. I shall explain why in simple language. The Secretary of State is responsible for a comprehensive health service. He produces a mandate, saying what he expects for taxpayers’ money, through the commissioning board and the other layers of commissioning. That mandate will be placed before Parliament, which can then debate it—at Question Time and in Adjournment debates, Opposition day debates and Government debates. That is holding the Government to account. Similarly, the commissioning board will produce an annual report that will be placed before Parliament. For the same reasons, it too will be accountable.

Even in a modernised NHS, I do not think that there will be any changes. Members will still be writing to Ministers about local health issues, about constituents’ health problems and so on, and they will also raise health matters at Question Time and in debates, asking about the configuration of the service or whatever. I cannot see how there could be a reduction in the accountability of Ministers and the Government to Parliament in the area of health provision. It is a fact, and hon. Members will have to live with that. They must accept that it is not changing or being diminished from what happens now, with hon. Members being able to hold the Government to account.

I wish to make some progress; first, however, I shall give way to the hon. Member for Leicester West.
Liz Kendall (Leicester West) (Lab): The truth is that the Government are in a mess over this. They wanted to push responsibility away and down, but that has frightened people and Ministers are now having to change the legislation. The Minister says that he does not want micro-management, but later amendments give the NHS board the power to tell consortia how often to hold board meetings, what the groups should be called and how to obtain clinical advice. That is micro-management.

Mr Burns: First, I assure the hon. Lady—she is a reasonable person—that the Government are not in a mess over this. Governments rarely do this, so she might find it strange, but, because we care so much about the NHS and its future success, we were prepared to listen and to pause. If we can strengthen and improve the proposals in light of the criticisms that have been raised—some genuine, some less genuine—we believe it is right to do so. We have listened and made changes that strengthen and improve the Bill and that meet some of the genuine concerns of organisations and individuals, both inside and outside the NHS. It shows our strength of character that we were prepared to do that. Many Governments would not do it; they would carry on regardless.

It is ironic that the issues that the hon. Lady raised on what management and clinical commissioning groups should do are things that have been called for to improve transparency and accountability.

Liz Kendall: Number of meetings?

Mr Burns: Indeed. It is all part of holding to account and having transparency, yet we are still criticised for it. Frankly, we have to move forward on the basis—[Interruption.] The hon. Lady has had her chance. She has blown it, and we are going to move on.

Grahame M. Morris: Will the Minister give way?

The Chair: Order. The Minister has indicated that he is not giving way.

Mr Burns: I said that I would give way in a minute, but let me finish. I did not expect to get any credit from the Opposition for doing the grown-up thing by listening and being prepared to make improvements, but I find it a little ironic that they criticise us for doing what they have urged us to do for a long time. Because I want to make progress, I am now going to give way to the hon. Member for Easington, as I promised. I will then make progress.

Grahame M. Morris: The Minister is being generous. May I set the record straight? He said that I had suggested that the Future Forum had not consulted staff as a stakeholder, but I did not say that.

Mr Burns: I said “unions”.

Grahame M. Morris: The Minister suggested that that is what I said. It is not that the Future Forum did not consult them; my issue is that when I specifically asked Professor Field whether the trade unions had raised their concerns—he gave evidence to the Select Committee on Health on 16 June, just after the report was published—and what the implications were in the NHS constitution for the changes to staff pay and conditions, he said:

“When we met with them, that question did not come up in the discussion with the unions.”

When the trade unions appeared before this Committee on Tuesday afternoon, I specifically asked that question of Gail Adams, and she responded: “As the—”

The Chair: Order. Much has been made of the amount of ground that we have to cover. We will not cover it if we have over-lengthy interventions.

Mr Burns: I understand that one of the hon. Gentleman’s complaints is that representatives of the unions were not consulted as part of the listening process. If I have misunderstood, I apologise profusely; no doubt we will both be consoled and reassured that the proof is in the pudding. The report shows that the unions did have an opportunity to input their views. I cannot comment on what went on in those meetings, because it was an independent forum at arm’s length from Ministers. I am not familiar with the minutiae of the meetings that were held by Professor Field and his colleagues.

May I get back to a more general point on the question of accountability? I have spoken, partly via the intervention of the hon. Member for Islington South and Finsbury, about accountability vis-à-vis Parliament, but I would also like to deal with the questions that were raised this morning about accountability and legal liability. I would like to make the point, as I have done already, that accountability to Parliament and legal liability are separate, albeit related, matters. The Secretary of State is accountable to Parliament for the health service, and that is not altered one jot by the Bill. In relation to legal liability, the board and the clinical commissioning groups have the primary legal responsibility to commission NHS services, as I have said.

Mr Burns: The hon. Lady made an interesting noise—I am too polite to suggest what it sounded like, but it is related to a pasture. [Laughter.] I think we will start again.

The Chair: That may be a good idea.

Mr Burns: In relation to legal liability, the board and clinical commissioning groups have the primary legal responsibility to commission NHS services, and they are legally liable for a failure to carry out that responsibility. The Secretary of State is not directly liable for a failure on the part of the board or a clinical commissioning group, or a failure by a provider. He is not liable, for example, if a hospital or a clinical commissioning group is negligent, but he is liable and could be the subject of a claim for judicial review by an affected member of the public if he fails to carry out his statutory duty under the legislation, including his duty to exercise his functions so as to secure the provision of health services under proposed new section 1(2) of the 2006 Act.
Opposition Members have tabled amendment 1, which would restore the Secretary of State’s original duty to “provide or secure the provision of services in accordance with this Act.”

Critics mistakenly believe that that duty is fundamental to the comprehensive service, but it is not. It is simply a means of achieving the overarching aim of promoting a comprehensive health service, not the test of whether that aim is being achieved. It does not even create a free-standing power itself. The duty in proposed new section 1(2) of the 2006 Act is a duty to “provide or secure the provision of services in accordance with this Act.”

The words “in accordance with this Act” mean that the actual powers and duties to provide and commission are set out elsewhere in the Act.

As I explained earlier, in the new legal framework that we propose, the Secretary of State would no longer have general powers to provide or commission services directly himself. Under the Bill, the duties and powers to commission NHS services are transferred to the NHS commissioning board and clinical commissioning groups, as I mentioned earlier.

The Secretary of State can provide or commission services himself, but only in exercise of his public health functions. If we kept the duty to provide, it would be a wholly inaccurate reflection of the framework contained in the rest of the Bill, which confers the functions of commissioning NHS services on the NHS board and clinical commissioning groups. If the Secretary of State were to retain those powers in parallel, that would enable him to cut across the board and clinical commissioning groups, undermining the mandate that he issues and the stability of the system, and opening the door to political micro-management, as I said near the start of my comments.

Emily Thornberry: What the Minister has just said is of huge importance, and I want to put on the record our alarm. If, for example, someone wants to take out a personal injury case because they have been treated badly in hospital following an accident, at the moment they would sue the Secretary of State. As I understand it, what the Minister has said indicates a fundamental shift of direction.

Mr Burns: You do not sue the Secretary of State.

Emily Thornberry: You take out the action against the Secretary of State. If I have got that wrong, I stand corrected, but it has highlighted exactly what our problem is. It is all very well for the Minister to say, “We can’t change subsection (2), because if we do, it will be inconsistent with the rest of the Act.” That is the whole point; that is the point of what we are saying. We are saying that the Bill is wrong. It is an attempt to take away political power from the Secretary of State and hand it to a group of quangos that do not have the same political accountability, in a cold climate of £20 billion-worth of—

The Chair: Order. I am sorry, but the hon. Lady is making a speech. I try to be tolerant in these Committees, but hon. Members must understand the difference between an intervention and a speech. If the hon. Lady wishes to catch my eye again when the Minister has finished speaking, she may do so.

Mr Burns: This is the nub of the matter. I just fundamentally disagree with the hon. Lady’s interpretation. She talks as though the situation is a new revelation. It is not. The whole ethos of the policy from before the election was that we did not want political interference in and micro-management of the NHS on a day-to-day basis. That has been the guiding principle, along with improving and enhancing patient care and giving greater decision-making powers to clinicians to be able to look after their patients.

Owen Smith: Will the Minister give way?

Mr Burns: No. I am sorry but I will not give way at all, because I want to finish answering some of the points that the hon. Lady made in the course of her rather long intervention. She said that, at the moment, an individual would sue the Secretary of State. That is not the case. If there is a problem, action is taken now against the PCT in the case of commissioners, or against the trust in the case of providers. Neither of them is the Secretary of State. The hon. Lady is wrong. The situation is the same now; it will just apply to different bodies. There is no sea change or difference in that.

I will move on. Hon. Members have asked what removing the words “to provide” means. The short answer is that although the Secretary of State must ensure that the NHS services are provided by, for example, exercising powers over the NHS commissioning board and other bodies, he has no responsibility to provide those services himself.

We should consider what a duty to provide means. A duty to provide involves having the premises and the staff necessary to offer health services directly. At present, the Secretary of State has a duty to provide, but even under the current system, that does not reflect the reality of a situation in which commissioning and provision rest with NHS bodies, not the Secretary of State. Retaining a duty to provide would not be an appropriate way forward for NHS services; it would be a retrograde step and utterly inappropriate, given the network of NHS commissioners and providers already set up to commission and provide services.

It is worth noting that, subject to a few exceptions, the duty in section 1(2) of the 2006 Act to “provide or secure the provision of services”, and the section 3 and 12 functions of providing or arranging the provision of particular services, have for many years not been fulfilled by the Secretary of State’s providing or commissioning services directly. Those functions are delegated to SHAs and PCTs. Although there is a small amount of direct provision of community services by PCTs, that is due to cease, because PCTs are almost entirely commissioning bodies.

In future, the split between commissioning and provision, which Labour Members supported while in government, will be even clearer, so that the board and clinical commissioning groups will not have the function of
directly providing services. The current system of delegated functions held by the Secretary of State but exercised by other bodies has led to confusion, as the debate today has shown. The framework established by the Bill will improve transparency and strengthen accountability by ensuring that all parts of the system have their functions conferred on them directly by Parliament in primary legislation.

Government amendments 55 and 56 make changes to the board’s core duty in clause 5 that are consequential on the changes to the Secretary of State’s core duty in clause 1. Amendment 55 replaces the current drafting of “act with a view to” with the words “secure that services are provided”, thus restoring the alignment between the drafting of the Secretary of State’s and the board’s overarching duties.

Amendment 56 sets out the Secretary of State’s public health functions, which were originally in clause 1 of the Bill but would be removed by the introduction of new clause 1. The provision is restated here because this is the first place in the Bill in which a clause distinguishes between the Secretary of State’s NHS and public health functions.

Government new clause 2 introduces a new duty on the Secretary of State to keep health service functions under review. The purpose of that is to make it clear in legislation that the Secretary of State is ultimately accountable for ensuring that the national arm’s length bodies, such as the NHS commissioning board, Monitor and the CQC, are performing their functions effectively. This duty is backed by extensive powers of intervention in the event of significant failure.

New clause 2 also gives the Secretary of State the power to report on how the national level organisations have discharged their functions as part of his annual report on the performance of the health service.

Fiona O’Donnell: Will the Minister give way?

Mr Burns: I will make progress. The hon. Lady has had many opportunities to contribute to the debate, and we need to move on because we are timetabled and there is still quite a lot to do.

I now turn to Opposition amendment 227, which relates to the Secretary of State’s duty to reduce inequalities. Helpfully, we established during the previous and extensive debates on this issue that we all supported the principle set out by clause 3, which is the need to reduce health inequalities, and agreed that it should be at the heart of Government decision making. Let me take the opportunity to remind hon. Members that this will be the first time that there has ever been a specific legal duty in relation to reducing inequalities in the health service in primary legislation. That reinforces our determination and commitment to reducing inequalities.

In the country, we have a good understanding of what health inequalities are and different ways in which we can work to address them. For example, we have accepted the analysis in the Marmot review and emphasised our commitment to a social determinants approach.

Grahame M. Morris: Will the Minister give way?

Mr Burns: No, I will not. This social determinants approach has been shared across Government and in our partnerships with others, including the charitable and voluntary sector. It has informed the development of other reviews, such as the Frank Field child poverty review and the Graham Allen review on early intervention, as well as Government strategies on social mobility, child poverty and, most recently, the natural environment White Paper.

We will continue to work through the ministerial sub-committee on public health and other bodies to underline the importance of the social determinants approach in tackling health inequalities. However, we also know that there is no easy answer or quick fix to reducing health inequalities. It is not something that the Department can do alone. The causes of and remedies for health inequalities lie across many areas of Government policy and beyond. Health inequalities are a societal problem.

The amendment would give the Secretary of State sole responsibility for the reduction of health inequalities, but that is not something that he can do alone, and it is not solely within the gift of the Department for Health. The duty in the unamended clause is more practical and achievable. It is intended to give him a duty to do the things that he can do on inequalities. The concern behind this amendment is that the need to strengthen the inequalities duty on the Secretary of State is misplaced. I will explain why the amendments do not do what hon. Members wish to achieve.

The clause as it stands reflects the language set out in the Equality Act 2010, which applies to all public sector organisations, including the Department for Health and NHS bodies. It places a legal obligation on the Secretary of State to consider how he can reduce inequalities and what more can be done to reduce inequalities whenever he is making any decision in relation to the health service.

The duty applies when the Secretary of State is exercising functions in relation to other bodies and not just when he is acting directly. That is important because it embeds the need to consider inequalities across all the Secretary of State’s functions relating to the health services and it entrenches those principles in all departmental policies.

2.15 pm

By contrast, the duty proposed by the amendment is narrower, as it will capture only the actions that the Secretary of State can take directly. It fails to recognise that in practice, much of the way in which the Department of Health can influence health inequalities is through the policies and objectives that it sets for other organisations, and I am sure that hon. Members would not wish to limit the Secretary of State’s obligations in this way.

The amendment is not necessary. The clause as it stands is more practical. The duty it places on the Secretary of State is more wide reaching and will achieve exactly what the amendment aims to do. It is for those reasons that I oppose the amendment. In summary, I invite members of the Committee to join me in supporting Government amendments 55, 56, new clause 1 and new clause 2 and in agreeing that the current clause 1 should not stand part of the Bill.
I hope that Opposition Members understand my reasons for rejecting amendments 1 and 227. However, should they wish to press the matter to a vote I invite my hon. Friends to join me in opposing the amendments. Because it is a little complicated, I will explain once more: I hope my hon. Friends will join me in voting for new clause 1 and new clause 2, Government amendments 55 and 56 and—this is the bit that may come as a bit of a surprise—voting against clause 1 standing part of the Bill and against amendments 1 and 227.

Grahame M. Morris: On a point of order, Mr Gale. Is it possible to speak in support of amendment 227 or have we finished this group?

The Chair: We had—possibly partly in your absence, Mr Morris—a fairly comprehensive debate on amendment 227. The ground was covered at some length this morning so I do not think it would be appropriate at this stage.

Emily Thornberry: I am attempting to check what the Minister said about legal actions and I am afraid that my research is not fast enough. However, I would appreciate a note about the changes to legal liability so my research is not fast enough. However, I would provide one.

If, after she has read my comments in this debate, she still wants a note, I will be more than happy to provide one.

Liz Kendall: I want to press the amendment to a vote. Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 4]

AYES
Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona
Thornberry, Emily
Turner, Karl
Wilson, Phil

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

Question accordingly negatived.

Clause 1 disagreed to.

The Chair: The question is that clause 2 stand part of the Bill.


The Chair: No. Let me explain again. We take the clauses in sequence as they are on the amendment paper. The other items will all be voted on, including for the hon. Lady, when we come to clause 3, amendment 227. The next item on the agenda is clause 2.
number of people waiting more than six weeks for diagnostic tests, including cancer patients, is double the number in the last four months in a row.

There is some measurement of quality; the quality of the experience undergone by the patient is substantially affected by having to wait more than four hours in A and E, for example. Is there any measure going on in Government and the Department of Health on the safety and the effectiveness of services? Simply to say that the Secretary of State “must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the...services” is not measuring them and finding out whether they are improving. If he cannot provide a definition of quality and has no measure by which to judge it, the clause is otiose. He must be able to measure the quality and effectiveness of services and to see whether safety and the quality of patient experience have increased. If the Government are not proposing that within the substantive and substantial changes to the Bill, frankly what is the clause really about? Is it, again, just window dressing? That is our concern.

Mr Burns: I will be brief, because, as hon. Members know, we had a very, very extensive debate on clause 2 the first time round. The hon. Lady has added nothing to that debate. She has sought to bring out some figures, which do not actually gel with the reality of what is going on, simply to try to score some political points.

The hon. Lady asked how we monitor things. It may come as a surprise to her, but the driving force behind how we want raise standards and achieve objectives within the NHS is through the outcomes framework. She asked whether we monitor what is going on, and the answer is, of course, yes. We constantly and consistently monitor such things as waiting times, the number of people who have treatments and so on. She mentioned safety, and we constantly look at safety through several mechanisms, because safety must be at the heart of the health service. We are doing a considerable amount, not least with the work on protecting whistleblowers, to drive up safety standards and attitudes towards safety.

The hon. Lady came out with some figures. I am not sure who her statistician is, but my hon. Friends will perhaps be more interested in actually getting the latest figures. If one is discussing average in-patient waiting times—

Liz Kendall: Will the Minister give way?

Mr Burns: No, no at the moment. Average in-patient waiting times are actually down, too.

Liz Kendall: Will the Minister give way?

Mr Burns: No, not yet. The hon. Lady may not find this so palatable, but she will get the whole menu before she can intervene. Average out-patient waiting times are down from 4.3 weeks in May 2010 to 3.7 weeks in April 2011. The average waiting time for those still waiting to start treatment is similar; it was six weeks in April 2011 and 5.5 weeks in May 2010, and it is lower compared with the end of last year. There will be changes from month to month, but the overall trend is a stable situation with average waiting times.

I may as well extend my point a bit, because I notice that we have the benefit of having a Welsh Member here. Wales is the only part of the Union where there is a full-blooded Labour Government, so let us have a look. In England, there is a pledge for a real-terms increase in funding in every year of this Parliament. We have honoured that so far and will continue to do so.

What do we find in Wales? I will quote the favourite organisation of the hon. Member for Islington South and Finsbury, the King’s Fund, which says that the Welsh Administration—the hon. Member for Pontypridd may be able to use this to find some defensive briefing when he is faced by his constituents—is cutting NHS funding in Wales by 8.3% in real terms over three years. If one looks at waiting times in Wales, written answers from the Welsh Assembly Government last week show that the percentage of patients who have been waiting more than 18 weeks when treated has risen from 20.9% to 26.4% in a year. That is between May 2010 and April 2011. That does not show that the operation of a Labour Government in power is particularly helpful.

Owen Smith: The Minister will, of course, know that cash spending on the NHS is flat in Wales and is not being reduced at all this year, the year after or the year after that. However, the overall funds available to the Labour Government in Wales to spend on all things is reduced by £1.8 billion over this Parliament as a result of the cuts made to their budget.

The right hon. Gentleman pointed out that they are a Labour Government, and I am delighted that that is still the case. Their budget rose every year of the 10 years that we were in power, and a Labour Government would have continued to increase the funding; the difficult decisions would not have had to be made.

Mr Burns: The hon. Gentleman can wriggle as much as he likes, but he forgets—[Interruption] If he keeps quiet for a minute, I will remind him that it was his Labour Government in the UK that left us with such a horrendous economic situation that the Government would have been cash-strapped, whichever party came into power. Whatever he says and whatever has happened, the unadulterated fact is that real-terms spending in the health service in England has increased this year, and will increase in every year of this Parliament. I said this at the beginning, but he does not seem to understand, so I will put it on the record again: the King’s Fund—not me, not the Government, but the King’s Fund—says that the Labour Welsh Administration is cutting the NHS in Wales by 8.3% in real terms over the next three years.

The Chair: Order. I appreciate that there will be a bit of skirmishing—that is what this place is about—but I remind the Committee that we are dealing with clause 2, not devolved powers. I would be awfully grateful if the Committee brought itself back to the matter at hand and remembered that we are dealing with the health service in England, not Wales. The Minister referred to Wales, so I felt it only right to allow the hon. Member for Pontypridd the opportunity to respond. We have now had our fun, so can we get back to clause 2, please?

Mr Burns: Thank you, Mr Gale. I want to conclude my remarks, but I promised to give way to the hon. Member for Leicester West, so I shall do that first.
Liz Kendall: I am grateful to the right hon. Gentleman for giving way. I know that the Government want to focus on average waiting times, but I respectfully say that when the number of long-waiting patients increases, as it clearly has in terms of those waiting for more than 18 weeks—[Interruption.] The right hon. Gentleman should listen.

Mr Burns: I am listening.

Liz Kendall: Just because the right hon. Gentleman pokes his ears, it does not necessarily mean he is listening. I respectfully say that the number of patients waiting more than six weeks for their cancer tests has trebled, rather than doubled, as my hon. Friend the Member for Islington South and Finsbury said, and more than one in 10 patients now wait more than 18 weeks for their treatment. The Government should be warned that when the number of long-waiting patients—the tail, as it is referred to in health policy—increases, it pulls the average wait up. The right hon. Gentleman may wish to defend himself by pointing to the average waits, but the long waits are going up. The Prime Minister’s pledge was about not average waits, but the number of patients waiting more than 18 weeks—a pledge that is already being broken.

Mr Burns: The hon. Lady said that the long waits at the end of the tail draw average waiting times down.


Mr Burns: Yes, up—that is, down in terms of a deteriorating position, but up in the hon. Lady’s terminology. I repeat that average waiting times are coming down, as the figures that I have just shared with my hon. Friends show. I will not be delayed. I urge Members to allow clause 2 to stand part of the Bill.

Question put and agreed to.

Clause 2 accordingly ordered to stand part of the Bill.

Clause 3

The Secretary of State’s duty as to reducing inequalities

Amendment proposed: 227, in clause 3, page 3, line 5, leave out from ‘must’ to ‘reduce’.—(Emily Thornberry.)

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 5]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona

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

NOES

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

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

Question accordingly negatived.

Clause 3 ordered to stand part of the Bill.

Clause 4

The Secretary of State’s duty as to promoting autonomy

The Chair: The question is that clause 4 stand part of the Bill. As many as are of that opinion, say aye.

Hon. Members: Aye.

The Chair: To the contrary, no. I think the ayes have it—

Emily Thornberry: I am sorry, Chair, but I believe that the Opposition Whip raised an objection to clause 4 being taken formally.

The Chair: There cannot be an objection to it being taken formally; it has been debated. Let me explain: in the grouping under clause 1, all these clauses were debated and put to bed.

Emily Thornberry: Not clause 4, though, Sir.

The Chair: The question on clause 4 has already been put, and there was no objection.

Emily Thornberry: There was.

The Chair: Order. I will make some exception for new Members, but the hon. Member for Sedgefield has been in the House long enough to know that if I put the question on a clause and nobody rises to speak on it, I put it to the vote. I did so, and nobody shouted no.

Phil Wilson (Sedgefield) (Lab): On a point of order, Mr Gale. I did shout no.

Emily Thornberry: He absolutely did.

Mr Burns: Can I be helpful?

The Chair: No, you cannot—I am ruling. I want to be absolutely clear that the Committee has had a fair crack, but the Committee has to understand that if the Chair puts the question and nobody rises to speak, and nobody votes against—nobody rose to speak—the best you can have is a Division. I am now going to put the question on clause 4 without debate, and if the Opposition wish to vote against it, they may do so. I hope that that is being fair to the hon. Member for Sedgefield, because nobody rose to speak.

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

The Committee divided: Ayes 13, Noes 9.

Division No. 6]

AYES

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

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

Question accordingly negatived.

Clause 3 ordered to stand part of the Bill.
Clause 5

The NHS Commissioning Board

Amendment proposed: 55, in clause 5, page 3, leave out lines 34 to 36 and insert—

‘(b) must exercise the functions conferred on it by this Act in relation to commissioning consortia so as to secure that services are provided for those purposes in accordance with this Act.’.—(Mr Simon Burns.)

Question put, That the amendment be made.

The Committee divided: Ayes 13, Noes 9.

Division No. 7]

AYES

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

NOES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Turner, Karl
Wilson, Phil

Question accordingly agreed to.

Amendment 55 agreed to.

Amendment proposed: 56, in clause 5, page 3, line 37, at end insert—

‘(5) In this Act—

(a) any reference to the public health functions of the Secretary of State is a reference to the functions of the Secretary of State under sections 2A and 2B and paragraphs 7C, 8 and 12 of Schedule 1, and

(b) any reference to the public health functions of local authorities is a reference to the functions of local authorities under sections 2B and 111 and paragraphs 1 to 7B and 13 of Schedule 1.’.—(Mr Simon Burns.)

Question put, That the amendment be made.

The Committee divided: Ayes 13, Noes 9.

Division No. 8]

AYES

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

NOES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Turner, Karl
Wilson, Phil

Question accordingly agreed to.

Amendment 56 agreed to.

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

Liz Kendall: Clause 5 establishes the NHS commissioning board, which is the start of the Government’s proposed reorganisation. It is important that we understand that the clause is key to the rest of the reorganisation, and that we consider what various organisations have said about the Government’s post-pause plan.

2.45 pm

The NHS Confederation’s briefing on the recommitted Bill raises the central issue that we need to discuss. The biggest challenge facing the NHS is making £20 billion-worth of efficiency savings. That would equally have been the case if Opposition Members had been in government. This last year has, in many ways—but not all—been wasted because of the distractions of the previous set of proposals, so even more money now needs to be saved over the coming years. The Committee does not have to take my word for it; consider what the Nuffield Trust and the NHS Confederation have said. They have had time to give some thought to the Government’s amendments.

The NHS Confederation briefing on the recommittal says that the post-pause reforms “do not sufficiently focus on the big challenges facing the NHS: making £20 billion of efficiencies over four years, providing a consistently high quality of care across the country, and providing better joined-up care for individual patients and their families.”

The Nuffield Trust goes further in its briefing, and makes this damning comment: “the main issue facing the NHS now and to at least 2014 is not the reform programme as set out in the Health and Social Care Bill, but the squeeze on funding. New commissioning models and the creation of a sector specific economic regulator are unlikely to impact quickly on productivity rates among the acute providers that are responsible for the largest proportion of NHS spending. Thus the crucial question is whether it is possible to extract the needed efficiencies now... will the revised Bill make that task easier?”

I hope we all know that the key to improving the quality of care and delivering better value for money is specialising some services in larger specialist centres and shifting others out of hospitals into the community, and doing more on prevention and joining that up with social care. When I asked whether the Bill would help us make those changes to hospital services, Dr Jennifer Dixon, who is one of the most respected health policy academics in the country and has been involved in running health services, said:

“I think it is a fine balance... I am agnostic.”

Professor Chris Ham, the chief executive of the King’s Fund said:

“I think it will be more difficult”.—[Official Report, Health and Social Care Bill Public Bill Committee, 28 June 2011; c. 28, Q62.]
Those are two of the country’s leading experts on health care policy. One is not sure whether the Bill will do anything to help the NHS meet the challenges it faces, and the other says it will make things even worse.

Dr Poulter: I am not sure whether the hon. Lady is not being rather disingenuous. I think the point being made by both witnesses was that there are key challenges that are driving efficiency in NHS services, and that more money must be directed to front-line patient care. Reconfiguration does not focus on that task. However, they did not pass comment on the longer-term impact of the suggested changes.

Liz Kendall: I always listen with great interest to the hon. Gentleman’s contributions, because he has been a front-line health care professional, and still is—I do not know if he still practises.

Dr Poulter: Yes.

Liz Kendall: Do you? That is admirable, if not a little amazing, considering the work load in this place.

I asked directly about reconfiguring services. Grouping together some services in specialist centres and shifting other care out of hospitals and into the community is precisely what we mean by reconfiguring services. The Government have said that they think that that does not make any difference to the task, or makes it harder, and they are agnostic.

Dan Byles: The hon. Lady is being very disingenuous, particularly in relation to Professor Ham, who said: “I think it will be more difficult to achieve reconfigurations at the necessary speed because there are more checks and balances... Sometimes that may result in better decisions.”—[Official Report, Health and Social Care (Re-Committed) Public Bill Committee, 28 June 2011; c. 28, Q62.]

Therefore, it is not as clear cut as she suggests.

Liz Kendall: In a moment, I will come on to the point that speed is of the essence, but I remind hon. Members that we need to make the efficiency savings now. My concern is that we have had a wasted year—although not in every aspect—because of the reorganisation, and that is certainly not likely to improve in the next couple of months.

Paul Burstow: I want to clarify a point, because the hon. Lady rightly identified the Nicholson challenge and the figure of £20 billion. In setting that context and understanding where the Opposition is coming from, it is important to understand their position with regard to the spending review settlement that the NHS secured. Do they support the settlement given by the Government, the spending review settlement that the NHS secured. In a moment, I will come on to the point that speed is of the essence, but I remind hon. Members that we need to make the efficiency savings now. My concern is that we have had a wasted year—although not in every aspect—because of the reorganisation, and that is certainly not likely to improve in the next couple of months.

Liz Kendall: I think that the Government’s proposed changes will not help or make the challenges facing the NHS any easier because they will make the system even more complex. Nationally, we will have the NHS commissioning board and Public Health England, which the Government now say will be independent from the Department of Health. However, I cannot see any amendment in the Bill that establishes Public Health England as a separate arm’s-length body. There will also be the new Monitor—believe me, I will not go into that now. Alongside those organisations, there is already the National Quality Board, NICE, and the Care Quality Commission.

Locally, there will be our GP consortia, now to be referred to as clinical commissioning groups. We will have health and well-being boards and the new clinical senates—I am not really sure what a clinical senate is or what it will do, and I particularly query why the word senate was used. Somewhere in between, there will be clinical networks, SHA clusters, PCT clusters, and possible outposts of the NHS board, or possibly not.

Fiona O’Donnell: Does my hon. Friend agree that the Government began by saying that the problem with the Bill was bad communication? The problem now, however, is that the Bill’s ambiguity is causing so much anxiety among organisations that provide health services, as well as patients, because it is not clear how all the organisations will work together or where responsibility will lie.

Liz Kendall: My hon. Friend is absolutely right.

Mr Burns: What, in Scotland?

Liz Kendall: The Minister may shout, “Scotland! Scotland!”, but Robert the Bruce he ain’t. [Interruption.]

The Chair: Order. Settle down, please. The hon. Lady is gently spoken. Members of the Committee might not want to hear her, but the Chair does.

Liz Kendall: Thank you, Mr Gale.

I list those bodies to show the sheer complexity of the new NHS structure proposed by the Government. As the NHS Confederation rightly warns, the new system could make it more difficult to make urgent decisions on reconfiguring local services, which is the point raised by the hon. Member for North Warwickshire. The NHS Confederation says that moving care into bigger specialist centres or out of hospitals and into local communities could make decisions far slower.

The clinical senates that the Government talk about in their response to the Future Forum will advise clinical commissioning groups on major service changes. Local authorities can challenge substantial reconfiguration proposals, and the Government’s so-called four tests on reconfiguration will be retained.

I stress that I am not in any way saying that we should not involve local authorities or have clear principles for making decisions on how services need to change, but there is a real danger that the whole system will be tied up in knots. When everyone is responsible, there is a risk that no one is responsible and, crucially, that no one is accountable for decisions.
I would like the Minister to answer these questions. First, if there is a proposal for reconfiguring hospital services, who takes the final decision? I have an example that relates to the independent reconfiguration panel, and I will not give a specific example—the Minister could get himself in trouble, and even I am not that cruel at this stage on a Thursday—but who makes the final decision if, say, a local hospital’s maternity ward needs to close? Is it the clinical commissioning group? Is it the health and well-being board? Is it the clinical senate, the NHS commissioning board or the independent reconfiguration panel? Can it ultimately be referred back to the Secretary of State?

It is not only about the big political questions of changing hospital services. Even now, services are commissioned in complicated ways. I used to be a director of the Ambulance Service Network, and ambulance services are a good example of how commissioning services is very confusing at the moment. Clinical commissioning groups will commission the urgent care bit of ambulance services and the NHS commissioning board will commission the emergency element. Who will commission regional services such as stroke and trauma? There are at least three different bodies commissioning ambulance services, which is very complicated. How do those things fit together?

Owen Smith: Is not a further complication introduced by this utterly confusing Bill that ambulance services are one of the precise areas in which there are no price tariffs? Potentially, there will be three different bodies commissioning ambulance services with no agreed price tariff. Is that not a recipe for chaos?

Liz Kendall: Commissioning NHS services has always been complicated, but the Bill will make it even worse. We now come to one of the consequences of the increased complexity in the system: the cost. A plethora of new bodies are being introduced. We had long debates in the previous Committee about how much the old bureaucracy, but we have a plethora of complex arrangements and an increase in the number of statutory bodies—of which the NHS commissioning board is one—from 160 to more than 530. How on earth can that be a bonfire of the quangos?

Grahame M. Morris: The Minister asked from a sedentary position what my hon. Friend’s comments had to do with clause 5. Judging by the arguments that the Government and their Front Bench team have made, part of the justification for the Bill is sweeping away bureaucracy, but we have a plethora of complex arrangements and an increase in the number of statutory bodies—of which the NHS commissioning board is one—from 160 to more than 530. How on earth can that be a bonfire of the quangos?

The Chair: Order. It may reassure the hon. Gentleman to know that if the hon. Lady was not in order, the Chair would be saying so.

Liz Kendall: My hon. Friend is absolutely right. The reality of the Bill is a huge increase in the number of bodies, which will increase costs. I will return to the point about the NHS commissioning board, because I want to keep my comments relevant to the clause. We now have a result of the Government’s response to the Future Forum that the NHS commissioning board will be responsible for commissioning the whole spectrum of services until clinical commissioning groups are ready, which is a huge responsibility. We know that the deadline for setting up clinical commissioning groups is April 2013, so the Government are proposing that one national body will be responsible for commissioning all those services before that date.

The NHS commissioning board will also be hosting clinical networks and clinical senates. I would like the Minister, if he can, to tell the Committee how many clinical networks there are now. He should know that, because the NHS commissioning board will be hosting them. I would like him to tell the Committee how many administrative staff they have and what the associated costs are, because that will move to the board. The NHS commissioning board will also host the new clinical senates, which the Government have said will cover every area. I would appreciate it if the Minister could tell us what an “area” is, and how many there will be. We have seen suggestions of 30 clinical senates. I would appreciate it if he told us how many senates and commissioning groups there will be. If he cannot say, I respectfully urge him not to say that the Government will be cutting costs, because he has no idea. Either he knows how many of those bodies will be set up, what the administrative costs will be and how many managers and other administrative staff they will employ, or he does not.

Mr Burns (rose)
Liz Kendall: I will let the Minister respond at the end, so that he can provide some evidence.

Owen Smith: I, too, have been intrigued by this. Do we have any idea from reading either the Bill or the amendments precisely what clinical senates will do?

Liz Kendall: No. I do not want to answer on the Government’s behalf, but, no, there is no idea what the senates will do—advising, along with clinical networks? I hope that the Minister will no longer claim that the Government’s reforms will reduce costs, unless he can prove how many bodies there will be, who will be employed and how much it will cost. I will let his officials help him with the response.

I would also like to know about the costs of the NHS commissioning board. How much will it cost to run? What is the difference between the old, pre-pause cost and the new, post-pause cost? It will host clinical networks.

Mr Burns: The answer, as I am sure the hon. Lady knows from experience, is that we are awaiting the impact assessment on the changes. She knows that, yet she stands there and keeps asking me those questions. She knows that until the impact assessment has been performed and published, no accurate answers can be given. I will not fall into that hole. I suspect her next question will be, “When will the impact assessment be available?” [Interruption.] She usually asks 101 questions like that. The answer is, when the legislation moves from the Commons to the other place.

Liz Kendall: I do not know why I temporarily forgot the Minister’s habit of asking my questions for me and giving my speeches. I have missed that.

We had not heard that there would be an impact assessment, so I thank the Minister for that. I am glad that there will be one. He has said that it will be published, and it would be good to know if that will happen before the Committee finishes.

Mr Burns: I have just told the hon. Lady. She was so keen to get a laugh out of saying that I anticipate her questions that she was not listening. I said that it will be published when the Bill leaves this place and goes to another place.

Liz Kendall: This place? That means that we do not get an impact assessment on the Bill while it is in the Commons. What kind of parliamentary scrutiny is that?

Mr Burns: The same as we got from you.

Liz Kendall: The Minister says from a sedentary position, that it is the same as he got from me, but I was not here until May 2010.

Mr Burns: I meant your Government.

Liz Kendall: The Minister says that he can, to tell us whether the NHS commissioning board will have regional outposts. I tell him, or perhaps his civil servants, that that needs to be addressed in the impact assessment. What are the estimated costs of retaining the clusters of SHAs and PCTs? That was not included in the costs in the Government’s previous impact assessment. What will the NHS commissioning board, with its new roles and responsibilities, cost? How many extra staff will it have? How many clinical commissioning groups will there be and what administrative or management staff will they have? I have the same questions about clinical networks. They already exist, so he should be able to tell us what their administrative costs are now. How many new clinical senates will there be? What area will they cover? How many staff will they have? Crucially, what are the opportunity costs of all those new bodies?

From speaking to various people in the service, I understand that GPs taking time out from their day-to-day care of patients to do their commissioning work means that locums must be brought in as cover. I have been told that that was not included in the Government’s estimates, because they have not asked primary care trusts. In their initial impact assessment, did the Government take into account the costs of bringing in locums to cover for GPs? How much will it cost to provide cover for hospital doctors, nurses and other clinical staff who will advise on the new clinical senates? The reason why I list all of that is because I want to be helpful and suggest to the Government that we will question them on those issues to determine the true cost of reorganisation.

My final point about clause 5 is the most important of all. It is not just that there is a big mess and confusion surrounding the Government’s plan, and it is not just that it will bring in a blizzard of bureaucracy with extra costs; our primary concern is the impact on patients. The reason why all of this matters is that this huge distraction means that patient care is already going backwards in some areas. We have had an exchange about waiting times, and the Minister and the Government should be worried about long waits. They should not be complacent and looking at the averages. They should be concerned, because constituents have already contacted me about the long waits that they face. The Government and the Department do not have a grip on those waits. On the one hand, the Prime Minister says that they back the pledge for no waits longer than 18 weeks, but waits are going up. The Department says that it is not a target, but is it monitoring the figures? Virtually abolishing waiting times was a huge achievement of the Labour Government. I remember the pledge card from 1997. The target was to take 250,000 people off waiting lists. People thought that we could not do it, but we did, and it is a precious legacy that the Government should look after.

The second way that patient care is already suffering, which the public almost do not understand or know about, is the time that we are missing out on to reorganise services. Joe Korner of the Stroke Association gave evidence to the Committee on Tuesday and made a passionate case for how stroke care had been transformed in London. I mentioned this in the previous Committee, and I will say it again: without some kind of regional ability to plan strategically, we are missing out on saving hundreds of lives by getting people to hyper-acute stroke units. On trauma care, we have known what we
need to change for years, and it requires a regional level. For goodness sake, do not have a road accident on a Friday or Saturday night when some hospitals do not have the very best consultants on call. We could be making those changes, and we are not, so lives are being lost. The board papers of SHAs or hospitals show that they are not doing that stuff. They are focusing on the reorganisation, and it is a tragic waste.

3.15 pm

My final point about the NHS board is one that I raised in the previous Committee, and it has not had enough attention outside or inside this place. The Bill includes a proposal for a national board to commission primary care, pharmacy and dentistry. I do not believe that a national body knows what GP practice is needed in New Parks in my constituency. Neither will it know that a pharmacy is needed on the corner of Stephenson drive because lots of older people live in that area. I raise the matter, because those are the services that transform care for patients, older people and those with long-term conditions—80% of patient care is in primary care.

In its briefing on the re-committed Bill, the NHS Confederation is rightly concerned about whether the NHS commissioning board will be able to performance-manage primary care from a distance and whether it will have the appropriate expertise. Apart from the problem of one national organisation managing more than 8,000 separate contracts, as well as those for dentists, pharmacists and optometrists, the absence of formal performance management responsibility might weaken the potential to drive improvement in patient care. Hon. Members on both sides of the Committee know the importance of improving primary community pharmacy and dentistry services. It is critical to improve care for older people and those with long-term conditions.

I say to the hon. Member for Southport, that they will manage-up standards in primary care.

First, there is a conflict of interest, because GPs might say, “There’s a gap—a need—in that area. They haven’t got enough good GP services there, but if we bring in a new GP service, will that take away something from our practice?” Secondly, during the evidence sessions, Jennifer Dixon, Chris Ham and others said that there was a role for GPs to help improve the work of their colleagues—for peer review. However, we know GPs do not always say to their colleagues: “You’re not doing great work there; you need to improve.” That is a very difficult thing to do. I urge the Government to think about their plans, particularly on primary care.

| Interruption. | I say to the hon. Member for Southport, I am trying, in my first speech in this Committee, to set out the problems with the new clauses and amendments and the continuing problems with the Bill. I hope that hon. Members understand that.

I stress that decisions about money are urgent. In my constituency, within two months of the financial year, University Hospitals of Leicester is £6 million in the red. I understand that there are particular issues in London. Within one month of the new financial year, Imperial College and University College London hospitals are £10 million in the red. In six months’ time the situation will be urgent, because hospitals up and down the country will face serious problems. That is what we should focus on. The Bill will not help us to meet that challenge, and patient care will suffer as a result. I urge hon. Members on both sides of the Committee to be aware of the impact on our constituents and on constituents across the country.

John Pugh: The hon. Lady made a number of points of practical concern, which we can discuss in a relatively apolitical way. They raise the question of how to get adequate local input into good primary service and commissioning. People are worried about how we relate peer review to the process of whatever the national commissioning board gets up to. Such concerns are legitimate, and I am sure that the Minister will respond to them.

I have one simple point to make to the Minister, which follows the helpful clarifications he gave in the previous debate. The Secretary of State is not really doing provision as such but provision is being done by the national commissioning board and commissioning consortia. The Minister made the very good point that we do not want parallel regimes where the Secretary of State overlays what people mandated to do that in a structured way are already doing.

I also understood that the Secretary of State retains considerable powers to step in, back-up powers when things go wrong and commissioning goes awry, and the power of general competence to deal with whatever may befall the arrangement. The beauty of this system, as he explained very well, is that it makes the split between commissioners and providers starker and clearer. Whatever one feels about that split, what he said about it was correct. My question is this: suppose the need exists for a new public provider such as a specialist hospital? One can think of examples of less significance, but clearly it could be a case where a new public provider might be needed.

In the past, there would seem to be a fairly straightforward way of accomplishing that. It would often be through the Secretary of State or someone to whom he gave delegated powers who would use the capital programme of the Department of Health and would create a new public provider. I foresee a hypothetical situation where it would not be possible to commission a social enterprise, there would be no social enterprise willing to step in and provide for this need, or where the private facility would only do it at an inordinate price that was simply not affordable, or led to risks with which the Department of Health or the commissioners were not comfortable. What is the mechanism for creating a new public provider or, to put it the other way round, what happens to the Department of Health’s capital programme? The capital programme is currently attached to strategic health authorities and so on.

This is important because the capacity to do it is necessary to guarantee a comprehensive service. Even if it is never exercised, that power should be there. Clearly if the commissioners and the national commissioning board have the power to create a new public provider, they would have to behave in an even-handed way towards that new provider if it was in competition with another provider. If they have that capacity—somebody has to have that capacity and the NHS commissioning board would seem to be the obvious body to have it in the new architecture—the absolute split between commissioner and provider is no longer there. The normal scenario we think of is the current environment
of the NHS where there is a multiplicity of providers and some of them are struggling to exist and always hoping for more business. In London, there is surplus hospital capacity. In other areas, that may not be the case; there may be a need for a new hospital facility.

Commissioners ought to be able to do two things. They can choose between existing providers or, in order to meet need, somebody—commissioners, presumably—has to create a new provider. That does not seem to be excluded in the Bill, but it is not apparent either. Clause 10 states:

“Each commissioning consortium may arrange for the provision of such services or facilities as it considers appropriate”.

I assume that if a consortium considers it appropriate to create a public body delivering a service, however small or however big, it can do that.

**Owen Smith:** The hon. Gentleman is making a very interesting contribution. Has he considered how the scenario he is painting would be affected if a commissioner or the Secretary of State wished to add to public provision of a health service in a given area? For example, new section 12E relates to the Secretary of State’s duty “as respects variation in provision of health services”.

The explanatory notes say that the Secretary of State, under the new legislation, would for the first time be precluded from introducing new provision, if that led to a variation in the proportion of public or private provision in a given area. The Secretary of State is now potentially going to be legally obliged to consider change to the variation in provision in an area, and might be unable to create, either through the board or directly, a new hospital, for example.

**John Pugh:** It is an interesting point. I am sure that when we get to that clause, that is territory we will have to cover. My point is very simple. We may find a situation in the NHS in future where the most obvious and sensible thing to do is to create a new public provider of sorts. The architecture of the legislation seems to indicate that that would drive us in the direction of saying that that is a commissioning body. There would have to be terms and conditions under which it could clearly do that. I am not convinced that it is excluded from the legislation as it stands. I have a question about how we handle the capital programme in the Department of Health, which is clearly the main agent for creating new public providers.

If I am right that the capital programme will overshoot the date at which we are meant to introduce the new system, it has to belong to someone and be within their remit. Having stated that question, I would be grateful for illumination, with an answer from the Minister.

**Owen Smith:** The hon. Gentleman is being very generous. Does he see another potential problem, which pertains to the comments made by my hon. Friend the Member for Leicester West, about the lack of regional insight into the needs of local health populations? In short, is it not less likely that a national body, such as the national commissioning board, will have the requisite oversight into local needs to be able to determine whether there ought to be a new public or private provider deployed in any given area?

**John Pugh:** The job of scrutiny is to anatomise the potential difficulties, and the hon. Gentleman has illustrated another one. I am not convinced that is such a big problem, but it certainly needs to be talked through.

**Mr Burns:** We have had a rather thoughtful debate. The hon. Member for Leicester West raised a number of interesting issues, although I could not agree with some of them, or some of the individuals she prayed in aid in support of her argument. The main thrust of a number of areas that she discussed was extremely germane, and it was interesting to hear her speak.

I do not want to rehearse the debate we had the last time round in Committee on the national commissioning board. As hon. Members will be aware, there are no amendments to the clause. Notwithstanding what has happened through the Future Forum, there has been no fundamental change in the direction or aims of the board.

I thought I would pick up a number of points raised by the hon. Lady and deal with them where I can. She asked a considerable number of questions about the costs, the implications of the amendments and the acceptance of the Future Forum’s proposals on cost. As I said to her then, I am not in a position at the moment to answer those questions, because it is a matter of producing a new impact assessment to reflect the amendments and changes to the Bill. I am surprised that the hon. Lady did not realise that that was going to happen, as it is in the public domain, and I have told her when we intend to publish that impact assessment. Information will then be provided that relates to a number of her questions.

3.30 pm

In that context and without going down a cul-de-sac, I should say that the hon. Lady rightly highlighted the financial pressures in the current economic climate on the health service. Nobody underestimates that. I can assure the hon. Lady that neither I nor other Ministers in the Department are complacent. We certainly are not. We fully appreciate the challenges of the economic situation that we inherited.

The hon. Lady almost exclusively portrayed, albeit interestingly, the gloomy and difficult side of the equation; she did not discuss in any detail the more positive side, such as cutting back on excessive and unnecessary management bureaucracy and the savings that that will generate. She also did not discuss the fantastic work that is going on throughout the NHS via the QIPP agenda. Those are positive things that will help to alleviate the problems and will release money that can go exclusively into front-line services.

**Owen Smith rose—**

**Mr Burns:** No. May I respond to the thoughtful speech of the hon. Member for Leicester West, rather than responding to constant interventions? [Interruption.] I meant those from the hon. Member for Pontypridd.

One of the questions that the hon. Member for Leicester West asked is why the board will commission primary care services—rather than, presumably, the clinical commissioning groups. As we discussed, the reason is that it could create too great a conflict of
interest if the clinical commissioning groups commissioned such services rather than a body that has no direct input from potential providers. I hope that has addressed the hon. Lady’s question.

The hon. Lady also raised the question of final decisions on reconfigurations. She asked whether the four tests introduced by the Secretary of State last summer will continue.

**Liz Kendall:** I know that they will.

**Mr Burns:** I thought the hon. Lady asked, but the answer is emphatically yes. They will continue.

On the question of who has the final say in decisions, commissioners, as the hon. Lady knows, lead on reconfigurations in most instances and work with providers. Local authorities will, through their overview and scrutiny committees, still be able to take a view, and OSCs will still be able to refer a reconfiguration to the commissioning board if they do not agree with it. If the board and an OSC cannot reach agreement, the OSC will be able to refer the matter to the Secretary of State and ask that he refers it to the IRP, as he can at present. I hope that reassures the hon. Lady. There will still be local democratic accountability on reconfigurations.

The hon. Lady also asked about clinical clusters and clinical networks. There is still work to be done on clinical senates. As she will appreciate from reading the Future Forum report, clinical senates were recommended in the clinical advice and leadership section of the report. The Future Forum recognises that clinical senates are a new idea in the context of the modernisation project. Paragraph 2.31 states that “we propose that the detail for their role and function, including their role in potential service reconfigurations, should now be developed.”

I am not in a position to give the hon. Lady the ABC of how clinical senates will work, how they will operate, and so on. There is still work to be done, but it will emerge. She will not see anything about the setting up of clinical senates in the Bill for the simple reason that primary legislation is not needed for the role that clinical senates will have.

The hon. Lady, if I heard her correctly, asked how many clinical networks there are. In the nicest possible way, I think that that question slightly misunderstands what they are now, because, as she genuinely appreciates, they are a mixture of local and national networks. We want that variety to continue, so there is no one-size-fits-all format. For that reason, it is rather difficult for me to give her a definitive answer that the amount of networks is x or y, because it does not work out like that—and I am not altogether convinced by the relevance of it either.

However, I will contest a point with the hon. Lady; it was the reason for my surprise when I gasped audibly at what she said with regard to Dr Gerada, whom the hon. Lady was praising in aid. I do not know Dr Gerada personally, but I am sure that she is a splendid person. However, I gasped in horror because the hon. Lady had followed loyally, and almost sheepishly, her right hon. Friend the Leader of the Opposition in quoting a bogus figure to pray in aid her contention that there would be a huge increase in the number of bodies and organisations within the NHS. That came from figures that Dr Gerada used in giving evidence to the Committee—

**Fiona O’Donnell:** Will the Minister give way?

**Mr Burns:** No—and she also fed them to the Leader of the Opposition.

The figure was about 521—something like that—which included the clinical commissioning groups and so on. It is a nonsense, frankly, to use that number, because it is not valid to lump them in as new quangos. [Interruption.] No, those are my words. They were lumped in as a global figure to say that we have x now, but by including those with other bodies, we are going to have x plus 100 times the number. I do not think that that argument is either valid or intellectually honest.

**Owen Smith:** Will the Minister give way?

**Mr Burns:** Yes, briefly, and for the last time.

**Owen Smith:** I am very grateful. In the spirit of intellectual honesty, if the Minister is absolutely convinced that we will not have 521 new statutory bodies under the new legislation, perhaps he will take the opportunity to tell us how many he thinks there will be. Can he give us a ballpark figure? Will it be 200 or 300? If he does not know, surely he should.

**Mr Burns:** Do you know—almost as soon as I sat down and started hearing the hon. Gentleman, I regretted giving way to him.

**Owen Smith:** He doesn’t know.

**Mr Burns:** It is not a question of that. I am not—[Interruption.] If the hon. Gentleman keeps quiet for a minute, he will hear. I am not going to get involved in statistical games because I am still scarred, as the hon. Member for Leicester West will know, from the designation saga on A and E in London and Cornwall, when I was simply trying to help in an illuminating way. From that, I learnt that one cannot engage in such a debate with Opposition Members without getting one’s fingers burnt.

**Phil Wilson:** Does the Minister agree with the NHS Confederation? In its written evidence, it says that there are “10 strategic health authorities and 151 primary care trusts” that make up the NHS. It goes on to state: “The proposed NHS structure is more complex with an NHS Commissioning Board,”—which will probably be the biggest quango in the world—“4 strategic health authority clusters, 50 primary care trust clusters (which will be reflected in the regional NHS Commissioning Board…) and possibly around 250 clinical commissioning consortia that will purchase secondary care services. Clinical networks and clinical senates will support commissioning consortia and 150 local government health and well-being boards will work in partnership with them.”

Are those figures accurate, too small or too large?

**Mr Burns:** I know that Opposition Whips are allowed to contribute to debates, but I think that they should observe the precedents that exist for Government Whips, because all the hon. Gentleman is doing is repeating the
points that the hon. Member for Leicester West and their leader have already made. I am not going to go down that route because we could, frankly, be here all afternoon. There are so many ifs, buts and qualifications to what I regard overall as a slightly bogus argument that I will leave it.

I turn to an important point that the hon. Member for Southport raised, which concerned whether the board could provide capital for a new service. The answer is that funding for highly specialised services has to take account of the fact that they are often very expensive to establish. Currently, the advisory group on national specialised services takes these issues into account when recommending whether a new service should be offered. We envisage a similar role in the future in advising on what services the board will be required to commission under clause 11. The board will take account of the full costs when agreeing the contract.

The hon. Gentleman also asked, albeit in passing, whether the system of capital funding from the Department of Health would continue in the modernised NHS. I can confirm that that is the case, although it is, as it has been for some years, a parallel system between capital funding in certain circumstances for certain types of trust, and the development in recent years—particularly among foundation trusts, because of their greater independence—of using the PFI system. We are looking at that with the Treasury at the moment to see what improvements and changes we can make to get better value for money for the taxpayer and the NHS.

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

Mr Burns: No, because I do not plan to speak for too long, as I said at the beginning. We had significant debates on this issue during our earlier consideration of the Bill, so all I will say in conclusion is that I urge my hon. Friends to support clause 5.

Fiona O’Donnell: I am grateful for the opportunity to speak. I had not planned to make a contribution, but because the Minister has not given me the opportunity to intervene I rise to ask some questions. I welcome the fact that the Nolan principles will apply to the appointment of commissioning board members, but I would like an absolute assurance from the Government that all meetings will take place in public and that all papers relating to those meetings will be made publicly available.

Furthermore, although an impact assessment will be welcome, it is unfortunate that that information will not be given to us at this stage of our scrutiny of the Bill. What direction has the Minister given officials in drawing together the impact assessment if he does not know, or is not willing to tell us, how many bodies are being created? Surely there must have been some definition of what those officials are assessing, or has the Minister simply asked for an impact assessment for 100, 200 or 300? I would like some clarification about the terms of that impact assessment.

Mr Burns: Will the hon. Lady give way?

Fiona O’Donnell: I will do so shortly, with good grace, but before I do I would like to issue a warning. I absolutely respect Mr Gale’s authority in keeping our proceedings in order, but it is not helpful for a member of the Government to shout the words “Scotland, Scotland” when a Scottish member of the Committee is speaking. I did not detect affection or endearment in the Minister’s tone.

3.45 pm

Mr Burns: All I wanted to say, because I do not think the hon. Lady fully appreciates it, is that the senates and the networks are not statutory organisations or quangos; they are clinical forums to advise.

Fiona O’Donnell: It is a great shame that the Prime Minister did not know that when he responded to the Leader of the Opposition yesterday. Perhaps we would have had some clarity before today. I am still interested to know how on earth the impact assessment will be carried out. On that note, I thank you, Mr Gale, for the opportunity to contribute further.

Debbie Abrahams: I, too, rise because I did not have an opportunity to intervene, and I hope to speak to clause 3. If I had been able to speak earlier, I would have followed on from my question on Tuesday, which was about health inequalities and how the amendments in the re-committed Bill would fulfil the duty to reduce health inequalities. What I was going to ask—I will ask it now—is how will the amendments contribute to reducing health inequalities? I give notice that I will be asking that on every amendment.

Liz Kendall: Thank you, Mr Gale, for allowing the debate to take place. It is important to cover these important issues at the beginning of the Bill. I want to make some comments in response to the Minister. My hon. Friend the Member for East Lothian commented on the impact assessment. Her contribution to the debate today has been fantastic; I am glad that she is here.

The Minister said that it was already public that an impact assessment was going to be done. I am glad about that, although I had not heard about it. First, is it normal to do an impact assessment after announcing what the policy will be? Secondly, as my hon. Friend the Member for East Lothian said, how can an impact assessment be done if it is not known how many different bodies there will be? I want to state again that I do not understand how an impact assessment on a Bill can be done without having that relevant information at the time it is discussed in the place where it is first introduced—the House of Commons. That is not right. I do not understand that.

Mr Burns: Can I help the hon. Lady on that?

Liz Kendall: I always appreciate the Minister’s help; it is so illuminating.

Mr Burns: I think I am right in saying that there have been times in the past when both Tory and Labour Governments—usually on Report or in the House of Lords—have significantly changed Bills by usually adding
more to the legislation. There has never been a subsequent impact assessment as a result of that. However, we are doing one on this legislation, because we have had the pause and the listening exercise, and there is time to do one in time for the Bill to go to another place. That is why it is happening. It is a positive step forward, because it will update the knowledge for those who are interested in our proceedings and for people within the House and another place. It will give them an updated assessment of what is happening financially on both sides of the equation as a result of the changes being proposed.

Liz Kendall: I do not want to go into past parliamentary procedure—the Government are making substantial and substantive changes—but what has happened to the Bill is unusual.

Owen Smith: It is far more than unusual; it is wholly unprecedented. As we heard in the re-committal debate, on only four occasions in the past 50 years has a Bill been re-committed and in none of those instances were more than three clauses re-committed. Today, we have started to reconsider the 60 clauses that have been re-committed. That is wholly unprecedented, as it would be for 60 clauses of new legislation to be scrutinised in Committee without our having an impact assessment, which the Government are obligated by law to produce to allow us properly to understand the cost consequentials.

Liz Kendall: My hon. Friend expresses the point far better and more accurately than I can, and I agree with him. It is wrong that we have not seen an impact assessment.

It is amazing that the Government can announce the policy of having clinical senates when they do not know what those clinical senates will do.

Mr Burns: We do.

Liz Kendall: The Minister has just said that that is all being worked up. How are clinical senates different from clinical networks? I understand that some clinical networks are local and some are national, and that some have been merged—for example, cancer, coronary heart disease and others have come together in some networks in the north-west—but is it appropriate that they are hosted by a national commissioning board, and how is what they will do different from what clinical senates will do? Bodies are not set up not knowing what they are going to do.

I would not have done what the Government have done, but I understand why they are concerned about conflicts of interest in the context of primary care. However, I state for the record what is happening in some parts of the country. As Pulse magazine reported yesterday, NHS Buckinghamshire has already handed the Practice plc, a private company that runs 60 GP surgeries and has recently acquired the UK provider arm of UnitedHealth, budgets to commission out-patient appointments and prescribing for 11,000 patients in two practices—Lyonet House in High Wycombe and Prospect House in Great Missenden. It has also devolved prescribing budgets to two other consortia within its boundaries. There is potential for clear conflicts of interest, because GPs may refer patients to a private provider arm from which they may benefit. Possible conflicts of interest are already happening now, but they should not exist.

The Minister has said that the Government are slashing bureaucracy, which we have already had a debate on. However, I point hon. Members to Government amendment 85, which will remove the ability of the Secretary of State to tell the board and consortia how much they can spend on admin costs. It is misleading and just not accurate—to put it at its kindest—for the Government to say that they have a strong grip on admin costs. If that is what the Minister wants, why is he deleting that power and responsibility?

The Minister said that I was sheepishly following Dr Clare Gerada and the Leader of the Opposition, my right hon. Friend the Member for Doncaster North. The Minister will know that I do not sheepishly follow anyone, but if I were to do so, there are far worse people to follow.

The Minister said that I and my hon. Friend the Member for Sedgefield, who I was delighted to hear speak, made bogus arguments about admin costs. We did not; we used information provided by the NHS Confederation. I trust its figures—I have to say that I did not; we used information provided by the NHS Confederation. It is far more than unusual; it is wholly unprecedented. As we heard in the re-committal debate, on only four occasions in the past 50 years has a Bill been re-committed and in none of those instances were more than three clauses re-committed. Today, we have started to reconsider the 60 clauses that have been re-committed. That is wholly unprecedented, as it would be for 60 clauses of new legislation to be scrutinised in Committee without our having an impact assessment, which the Government are obligated by law to produce to allow us properly to understand the cost consequentials.

Liz Kendall: I do not want to repeat the debates that we had the last time that the Committee discussed schedule 1. However, because the NHS commissioning board has gained new powers and responsibilities, both from the amended legislation and from the Government’s policy response to the Future Forum, the fundamental issue that we raised the first time round is even more important now.

I remind hon. Members, as they all are listening so intently, that schedule 1 deals with how members of the NHS commissioning board, including the chair, chief executive and executive and non-executive members, are appointed. Committee members will remember that there was some concern last time we met as a Committee
that David Nicholson, the chief executive of the NHS, had been appointed as the chief executive of the board. A freedom of information request, which I think was submitted by the *Health Service Journal*, had revealed that he had been appointed without any job description or person specification. The suggestion at the time was that he was appointed because the Chancellor of the Exchequer had been worried about what was happening in the Department of Health and had decided, on the advice of the former Secretary of State, the right hon. Member for Charnwood (Mr Dorrell), that somebody such as Sir David should be in charge of the board in order to get a grip on finances in the NHS.

Serious concerns were raised not only by Opposition Members, but by several external organisations. They were particularly concerned about the appointment of the chair and the non-executive members of the NHS commissioning board, because those roles, as schedule 1 clearly states, will be appointed by the Secretary of State. We tabled an amendment that stated that the appointment should be conducted through an open, transparent and fair process. Great power and responsibility have been given to the NHS commissioning board. David Nicholson told the Public Accounts Committee that he is the one who will ultimately be responsible to them for the entire commissioning budget. The board will be responsible for ensuring that the Secretary of State’s mandate is delivered on the ground, and we had a huge debate about that today. However, the board members will be political appointees. They will be chosen by the Secretary of State, and there is a real concern.

[Interruption.] The Minister is looking quizzically at me, but schedule 1(2)(1) states:

“The Board is to consist of—

a chair appointed by the Secretary of State at least five other members so appointed”,

and, as I understand it, the non-executive members will appoint the other members. That is quite a lot of power to give to the Secretary of State. A better approach by far would be to conduct the appointment of the chair and non-executive members in accordance with the Nolan principles.

Our last amendment suggested that it should happen through the Appointments Commission, but the Government are planning to abolish that. It is not only us: the NHS Confederation, which has some experience in trying to ensure that there are effective boards in place, has said:

“Given the extended role of the NHS Commissioning Board, there is an even greater need for it to be accountable, not just to the Secretary of State but at all levels.”

The BMA also remains concerned that the arrangements lack sufficient transparency and remove the ability of the board and its members to operate free from political influence and control. I am once again helpfuly saying to the Government that they are not even doing their own policy effectively.

It is interesting that, in response to the Future Forum’s recommendations on clinical conditions, the Government have said that their governance arrangements should comply with the Nolan principles of public life. They have agreed to do that for the clinical commissioning groups, but not for the NHS board. Why not?

Will the Minister also update the Committee on the progress of setting up the board? I understand that we paused while the Government were listening. How have they advertised the appointment of a chair of the NHS commissioning board and of non-executive board directors? Has the appointment process for any of those posts begun? With so much power, responsibility and authority, the people who will run the board should be appointed in an open, transparent and fair process. That is not what schedule 1 provides for at the moment, but the Opposition, professionals and other health bodies believe that it should.

Mr Burns: This has been a short debate, although I suspect that it is probably because we discussed schedule 1 significantly in our earlier proceedings. Having said that, the hon. Lady raised several specific questions about the commissioning board, referring particularly to its structure and the appointment of its executive and non-executive members, quoting the rules outlined in paragraphs 1 and 3 of schedule 1.

I do not recognise the hon. Lady’s interpretation of the individuals who will presumably be appointed to the board. I reject the whole idea that they will be political appointments. That has all the connotations, which she would believe, that we would have people stuffing an organisation to pursue one political party’s agenda. I reject that totally because I have no doubt that the individuals who will be appointed will be of the highest calibre and have the best qualifications and training from their backgrounds to be able to carry out an effective job to ensure the success of the NHS commissioning board in the tasks that it has to undertake.

The hon. Lady went into more detail about her interpretation of the appointments. The Secretary of State will indeed appoint the chair and the non-executives, but that is perfectly normal, with lots of precedents, for arm’s length bodies of Departments. It is exactly the same as what happened with the appointment of the Care Quality Commission, and I think I am right in saying that the CQC was set up and the appointments made under the Labour Government. If it is was all right then, and they were not stuffing the CQC with political appointments, then I think it is all right now, and it will not be about stuffing the board with political appointments. There has to be some consistency. If it was perfectly all right and acceptable to the previous Government to use those procedures, it is perfectly right and acceptable now. She must also remember that appointments will, of course, be made within the remit of the code of practice set out by the Commissioner for Public Appointments. I am afraid that I share neither her take on the situation nor her concerns.

The hon. Lady also asked if it was true that we had advertised for the chair for the NHS commissioning board. The answer is that it has been advertised once and the Department will shortly be advertising again.

Grahame M. Morris: On accountability and holding to account a quango that will be responsible for spending in the order of £80 billion, is it the intention, as with the CQC, that the House of Commons Select Committee on Health will ratify or consider the appointments the Secretary of State recommends?

Mr Burns: I explained in my comments and, if my memory is correct, when we went into it in great detail earlier, that the procedures are similar to those carried
out under the previous Government, and we believe that they are the right ones. The hon. Gentleman diverts slightly by asking whether the Health Committee should ratify the appointment—I think that was how he put it, a yes or no will suffice.

Grahame M. Morris: The appointment of the chairman of the CQC was.

Mr Burns: The Health Committee called the chairman of the CQC for interview after her appointment, so that they could discuss how she saw her role and how she would progress within the organisation. That is a perfectly respectable and sensible thing for a Select Committee to do. There are no powers in the House of Commons arrangements for a Select Committee to interview candidates in advance or make appointments, and, personally, I would reject the idea, because I do not think that it is the best way forward. Once the board has been appointed, I see no reason why the Health Committee cannot invite it to give evidence. Frankly, I would be surprised if it did not call the board members in to discuss how they saw their role and the role of the board developing under their stewardship.

An advantage with the excellent Sir David Nicholson, who will be the chief executive of the board when it is established, is that the Health Committee has interviewed him on a number of occasions on NHS matters, so it has access to him now—albeit in a different position—and dealing with issues that will be germane to the board. I do not think the hon. Gentleman should be too worried.

The hon. Member for Leicester West asked about the progress with the board in recent months. We have said that we will seek to establish the board in shadow form as a special health authority later this year, so that it can begin to move forward. I hope and trust that she finds that update helpful. I conclude my remarks by urging my hon. Friends to support schedule 1 standing part of the Bill, if the question is pressed to a Division.

4.30 pm

Liz Kendall: I thank the Minister for his response. I did not say that this was about stuffing the board—

Mr Burns: That was my word.

Liz Kendall: That was the right hon. Gentleman’s word. I said they were political appointments; I did not say that they were political appointees and that it was about stuffing the board.

Mr Burns: If it helps to reassure the hon. Lady, who possibly because of the lateness of the hour seems to be becoming a little sensitive in the cut and thrust of the debate, I can confirm that she never said the words “stuffing the board.” They were my words and it was my use of the vernacular. However, the underlying impression from her comments was that that was the implication of what was going to happen.

Liz Kendall: I respectfully suggest that if anyone is acting in a slightly sensitive and paranoid way it is the Minister.

Mr Burns: Moi?
Liz Kendall: I understand that. My point is whether it is right that the members of the national commissioning board are appointed as currently proposed in the Bill. I do not think that that complies with the standards that we would expect of other bodies with responsibility for public funding. It is probably more important for this national board. For that reason, I still have serious concerns about the schedule.

Question put, That the schedule be the First schedule to the Bill.

The Committee divided: Ayes 11, Noes 9.

Division No. 9]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Byles, Dan
Crabb, Stephen
de Bois, Nick
Lefroy, Jeremy

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

NOES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona

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

Question accordingly agreed to.

Schedule 1 agreed to.

Clause 6

COMMISSIONING CONSORTIA

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

Liz Kendall: The clause establishes commissioning consortia. I think I understood what the Minister said during his point of order at the beginning. They are still called commissioning consortia for the moment.

Mr Burns: This can be confusing. As the hon. Lady knows, they are going to become clinical commissioning groups, and every reference in the Bill will have to be changed at some point to reflect that. For the moment, we will continue to use the old terminology, in legal and drafting terms, in relation to any amendments that are to be considered during the re-committal stage of this Committee. On Report, however, we will introduce all the amendments needed to change all the references from the existing terminology to “clinical commissioning groups.”

Liz Kendall: I am grateful to the Minister for confirming that. I want to raise three points in relation to the clause, which will establish the new groups, and they are the main concerns about the Bill, post-pause. The first is the important issue of the pace of change. Some groups are moving at different speeds from others. On page 6 of the response to the NHS Future Forum report, among other interesting things, the Government say that “commissioning groups will all be established by April 2013—there will be no two-tier system. They will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so”.

It goes on to say that “where a commissioning group is ready and willing, it will be able to take on commissioning responsibility earlier.”

I do not understand how that can be anything other than a two-tier system, where one group gets the money to go ahead and make changes and the other does not. I do not understand how what the Government have proposed is not a two-tier system. As I made clear in my earlier comments on clause 5, we are already seeing that happen in parts of the country.

Sometimes there are concerns about what that means. For example, there is the case of NHS Buckinghamshire, where the budget for commissioning out-patients and prescribing has been handed over to The Practice plc and private practice. People including Dr David Jenner from the NHS Alliance and Dr James Kingsland, who are not usually critical of the Government’s policy, have said that there would need to be benchmarks for probity to ensure that patients were offered a choice and not directed to clinics run by the companies from whom those doctors would benefit.

I have three points. First, there will be a two-tier system. Some GPs will have their hands on the money to make changes for patients, but others will not. We might end up having a debate about the number of GPs who signed up to the pathfinders. Dr Clare Gerada said in her evidence that she had, although that was not because she was particularly enthusiastic, but because she felt that that was where things had to go so that they joined up. Others will be very enthusiastic. Some GPs in my patch are enthusiastic about that bit of the Bill, but they do not like the Monitor aspect. While there will be a two-tier system, there actually already is in some parts of the country—that is just a statement of fact. The concern is whether that starts to lead to differential care for patients.

Secondly, there are concerns about probity, proper accountability and measures to prevent conflicts of interest. I would not mind the Minister writing to me on the NHS Buckinghamshire case to set out how it was ensured that there were not conflicts of interest when a private company of GPs came in. They may well be referring patients to that clinic—I do not know, and I am not saying that they are—but I just want to know what safeguards are in place.

The third issue is one about which I am deeply concerned in my patch. I mentioned Dr Teck Khong earlier. He is a leading GP board member on the Leicester commissioning group. He was a parliamentary candidate in Bradford North and he tried to become the Conservative candidate for the Leicester South by-election, so his parliamentary aspirations are still alive. A couple of weeks ago, in an article on Conservative Home, he said that an explicit list of services should be excluded from state provision, because we cannot cope with the costs we are looking at now.

I want the Minister to comment on this, if he will let me finish my remarks. People have been worried about the endgame plan. If GPs are in control of running and buying services, they are also businessmen. They will end up being, as Dr Clare Gerada and others have said—[Interruption.] I suggest that the Minister does...
not make any more asides about Dr Gerada. A GP, when faced with the patient sitting in front of them, will be thinking not only with their clinical head, but with their profit head as well.

Julian Sturdy (York Outer) (Con): Is the hon. Lady saying that GPs are in this purely for profit? Is that what she said?

Mr Burns: Yes.

4.45 pm

Liz Kendall: I am surprised by the hon. Member for York Outer, because he usually listens carefully. I said that people are concerned. Dr Clare Gerada said in her evidence that people feel that when they go into the surgery, their GP will no longer look at them purely on the basis of what they need as a patient because the GP will also be thinking about balancing the books. Clare Gerada thinks that is a real danger. Hon. Members can read the evidence and see. She said that she was worried about the impact on trust between patients and their doctors. People will no longer believe that doctors are making the right decision based on them because of a belief that GPs will be thinking about their balance sheets.

It is important that clinicians are engaged in the costs of their decisions. Dr Teck Khong says that the system is unsustainable unless we exclude patients from parts of the NHS. I am not saying that Dr Khong is representative, but I am really worried for patients in Leicester.

Nicky Morgan (Loughborough) (Con): The hon. Lady cannot have it all ways, but is not that the problem with the Opposition’s whole approach to the Bill? On the one hand, they float all sorts of ideas and scare stories but actually, as the hon. Member for East Lothian said, patients are at the heart of this. Patients know and trust their GPs not to think about how much they are going to pay, but to give them the right care. It is patients who are at the heart of this.

The other point is that the hon. Member for Leicester West cannot attack the Minister for having his views about Dr Clare Gerada when she is attacking somebody else who is also not here. I do not know Dr Teck Khong. The hon. Lady is right about his involvement in Leicester, but I think that we would all agree, as politicians, that we have members of our parties who say things publicly that are in no way representative of what the party thinks. She and Opposition Members really should exclude from state provision.

Liz Kendall: My hon. Friend makes an important point. It is not only Labour Members who are making that point; it has been made by leading doctors themselves.

Debbie Abrahams: Is my hon. Friend aware that when a systematic review—that is the strongest form of evidence—examined the relationship between financial incentives and trust in patients, it showed that when such incentives were involved, there was an eradication of the relationship and trust between patients and GPs? We are not the only ones saying that; there is strong evidence that that happens.

Liz Kendall: My hon. Friend makes an important point on the basis of her experience and background, particularly in public health. I think that that is linked to fear about the GP bonus, which we shall address later, and the ability to reward GPs. People fear that saving money will be part of that.

Dan Byles: It is unfair to discuss Dr Teck Khong in such detail without reading out what he actually wrote. I am happy to do so. I feel it is unfair that he is being bounced across a table.

Liz Kendall: I am happy to read out what Dr Teck Khong said: the Government “must not flinch from setting out an explicit list of services to be excluded from state provision.”
**Dr Poulter:** I know that we are going to debate this matter later, but the hon. Lady did raise the point specifically. How does she square the view she expresses about bonus with the fact that the previous Government introduced quality and outcomes framework payments for GPs, which increase the average GP’s income by £35,000 a year?

**Liz Kendall:** The QOF regime, as the hon. Gentleman knows, tries to link clearly specific goals for clinicians, such as the number of patients who have vaccinations or statins. The concern about the bonus payment is around links to efficiency savings, so cost decisions will be made, not just quality decisions. I know that, by convention, the hon. Member for Broxtowe, as a Parliamentary Private Secretary, does not speak. However, she wanted to know why we were picking on one GP. I am talking about him because he is a board member on a commissioning group in my constituency. I do not want a GP who is supposed to be responsible for delivering care for my constituents saying there should be an explicit list that is rationed, and that was why I used him as an example.

**Several hon. Members rose—**

**The Chair:** Order. I am reluctant to intervene in proceedings, but I am going to have to ask the hon. Lady to draw this line of debate to a conclusion. Hon. Members from all parties have had an opportunity to intervene, and the hon. Lady has been generous in giving way. It is always dangerous in this place to attack personally somebody who is not present and cannot defend themselves, but that is true of two people who have been named this afternoon. We are also beginning to stray rather a long way from clause 6, although I see that the hon. Lady has been talking about commissioning. Perhaps she might now make her remarks more general.

**Liz Kendall:** Of course I obey, Mr Gale.

I believe that anyone is perfectly entitled to their views about the future of health care. What is difficult is that I am trying to bring the massive Green Paper to life and determine what it means. The best way to do that is to refer to the people I represent. I am sure that the gentleman in question can make his own comments. If he wishes to write to the Committee, he will be able to do so. I do not ever mean to attack an individual; I always try to focus on the idea. I am obviously happy to continue to debate with all hon. Members.

I have tried to raise the concerns that exist about the establishment of commissioning consortia, and I hope that we can follow that in greater detail when we debate other amendments. I hope that the Minister will respond to my points.

**Jeremy Lefroy** (Stafford) (Con): I rise to ask for a brief point of clarification from the Minister. On Tuesday, I asked the Secretary of State about the Future Forum report, which states that “the boundaries of local commissioning consortia should not normally cross those of local authorities.”

In his reply, the Secretary of State implied that local authorities were defined as “upper tier or unitary” and not as boroughs or districts. Will the Minister clarify the position in his concluding remarks?

**John Pugh:** I want to respond to the hon. Member for Leicester West because she got a number of things muddled up. I am not remotely interested, personally, in what is happening in Leicester West or in the individuals she spoke about. However, the difficulties that she expressed apropos the commissioning consortia would have applied if the Government had gone for what would have been my favoured option: clinicians on the boards of the PCTs. There would have been exactly the same conflict of objectives, because an individual clinician would have had to think about the needs of the patient while thinking about how to control a budget, and that would apply if the hon. Lady’s favoured solution to have greater clinical involvement were implemented rather than the Government’s.

That matter is quite separate from a conflict of interests, which is when a GP personally stands to gain financially from the arrangement in some way. Obviously, protections must be provided in the registration in order to do that. I was concerned that Assura Medical, which is a provider to the NHS, was also forming partnerships with GPs and that some of those partners ended up playing leading roles in commissioning consortia—on pathfinders. Assura and the Department recognised that that was inappropriate and not how things should be done.

There are dangers in clinicians not thinking of money at all and prescribing willy-nilly the most expensive drugs and so on, regardless of whether generic drugs are cheaper. There are also dangers in clinicians thinking too much about money—thinking not of their patients’ interests, but purely of managing the budget. I want to make the general point, however, that if we think that clinicians are incapable of handling this responsibility in a professional way that is fair to their patients and to the commissioning community, we simply should not get them involved. If they are going to be involved, they must deal with balancing the objectives.

**Owen Smith:** Does not the hon. Gentleman accept that there is a fundamental difference between clinicians managing their budgets, as they currently do—we accept that they absolutely need to do so—and the new scenario? Under the Bill, the bonus that is payable by the board to the consortium—the quality premium—may be contingent on the value-for-money savings or efficiency savings delivered by that consortium. Equally, as Jennifer Dixon highlighted in her evidence, we do not know whether consortia will be able to keep their surpluses at the end of the year as they did in the pathfinders. Neither of those things is clear in the Bill, and until they are clear, our concern is absolutely legitimate.

**John Pugh rose—**

**The Chair:** Order. I am sorry to interrupt the hon. Gentleman. It has been drawn to my intention that the deadline for tabling amendments that relate to Tuesday’s business is when the House rises today, not the Committee. The Minister is now speaking on the Adjournment, so the House is likely to rise shortly. Hon. Members who intend to table amendments have about five minutes to do so. Amendments may be handed to the Committee Clerk.

**John Pugh:** The hon. Gentleman, as usual, runs ahead of me—he is far quicker in these matters than I am. I am aware of the issue he raises and we need to debate them when they arise later in our proceedings.
The generic criticisms made by the hon. Member for Leicester West relate to matters that are intrinsic to any system with clinicians involved in commissioning. As such, they are not valid criticisms of what the Government are doing. In the Bill, they are trying to ensure adequate protection against conflicts of interest, but they recognise, as clinicians themselves do, that there is always a dilemma when a doctor has a dual role and must think about a budget and the interests of his patients. However, do we not assume that all doctors reconcile that conflict within themselves in a wholly professional manner?

Fiona O’Donnell: I am grateful to the hon. Member for Loughborough. It is important to breathe some life into the amendments, making them live for patients, but the outrage of Government Members is wholly unjustified when they accuse us of scaremongering. I prefer to call it legitimate concern, which does not come only from Members, but from the Lib Dem conference and many other organisations out there. We are having a “Groundhog Day” moment, because we experienced the same thing during the debates on welfare reform—[Interruption.] If the hon. Member for Winchester wishes to contribute, we will all be pleased to hear from him.

Mr Steve Brine (Winchester) (Con): If it seems like “Groundhog Day” to the hon. Lady, she should remember the other Committee members, because the Opposition’s arguments are going around and around.

Fiona O’Donnell: It is the U-turns that take the Government around and around. We continue to spin around and around in pursuit, in the hope that the Government will see the need to change.

As I said, similar arguments were advanced in the debates on the Welfare Reform Bill, when we were accused of scaremongering on the removal of the mobility component of the disability living allowance for people in residential homes. The job of Government, however, is to introduce good legislation that is not left open to such concerns and anxiety. When patients—especially people with complex medical conditions—are stuck down in front of their GPs, it is crucial that they have complete confidence.

We have had representations, especially from parents with children with physical and learning disabilities, making it absolutely clear that the services offered are in the best interests of their child and that there is no concern. Government Members are nodding but they should have been able to introduce a Bill to this House that reassured. Clearly, they have not done so, because it is not only Opposition Members who have expressed concern.

Nicky Morgan: The difficulty with what Labour Members are saying is that they are questioning the ability of GPs to know the difference between good patient care and good commissioning. The problem is that the hon. Lady and her colleagues, including the previous speaker, are saying that GPs are not capable. How many people has she has met who, when they go to see a doctor, do not trust that they are getting the best possible advice? They want the best possible advice and the best possible treatment, and they will trust the doctor for that, but she is saying that GPs will not be capable of providing it. I think that is wrong.

Fiona O’Donnell: I think that it is absolutely wrong of the hon. Lady to misrepresent me. At no point have I said that GPs are not capable. I have said that the Bill—this bad Bill, and it was the Deputy Prime Minister who said, “Better no Bill than a bad Bill”—opened the worry for patients. Government Members must take responsibility for creating those concerns. I am not talking down anyone in the medical profession, but we know that some GPs out there might not be operating with the best interests of their patients at heart. [Interruption.] Pardon? Does the hon. Lady wish to intervene?

Nicky Morgan: The hon. Lady is starting to say that some GPs are not capable, so she is criticising some GPs after all.

Fiona O’Donnell: There has been some criticism, and some patients have challenged their doctor’s decisions on drugs prescribed. Those are choices that the doctors have made. In the past, we have not had to question whether they made those decisions on the basis of securing a bonus, but the Bill will leave that question open.

Dr Poulter: The King’s Fund, which was quoted earlier by the Labour Front Bench, pointed out that under the current GP system of bonus QOF payments some GPs far too often follow the bonus payments in what they prioritise in the surgery for treating their patients. That is a problem in the current system but, also, many bonuses are based on financial incentives and how practices improve financial management. How does that sit with what the hon. Member for Leicester West said in her previous remarks? She said that she does not like that bonus system or like it that GPs are in any way rewarded for good financial management.

Fiona O’Donnell: The most important incentives are clinical. Such incentives were put in place by the previous Government to increase the number of vaccinated children. Those incentives were about improving patient care.

Debbie Abrahams: We know that the evidence on financial incentives and on improvements in patient outcomes is mixed. As the hon. Member for Central Suffolk and North Ipswich knows, QOF was introduced when the evidence was even poorer and even sketchier. We now know, because of QOF, that financial incentives jeopardise trust between GPs and their patients. We know that such incentives contribute to increasing inequalities, too. So we must be mindful and look at the strong evidence when we talk about financial incentives.

Fiona O’Donnell: I am grateful for all that my hon. Friend has contributed to the quality of our consideration of the Bill and for the experience that she brings to it. The Ministers should be seeking to reassure not only us, but patients, patient organisations and the voluntary organisations that deliver services, that this Bill is safe. As I see it, it is not a safe Bill; it is a bad Bill.

Mr Burns: I will begin by dealing with the two points raised by the hon. Member for Leicester West on individual cases, rather than the three policy points that she raised. The first point was about a gentleman associated with commissioning in Leicester who I do not know.
Liz Kendall: He is a board member.

Mr Burns: He is a board member in Leicester. The hon. Member for Leicester West mentioned an article that that gentleman apparently wrote on a website, which I also have not read. If I had read it, I would have thought that it was an individual setting out his views of what should be done.

What I do as a job, and what my colleagues do in Parliament, is ensure that the Government’s policies are pursued, and the Government’s policy is that the NHS should be free at the point of use for all those eligible to use it. We do not, have not and will not agree to the idea that one should draw up lists of medical treatments that should be excluded. An individual may have that idea, and he may contribute to the debate, but it is not an idea that finds favour with the Government, although, in certain circumstances in which there is almost unanimous agreement, the NHS does not provide certain types of treatment.

So that the point cannot be misconstrued, I should say that an obvious example is that the NHS does not remove tattoos free of charge from people who have become bored with the pattern or who have changed girlfriends.

Owen Smith: Maggie.

Mr Burns: Hillary, actually.

The hon. Member for Leicester West also mentioned a situation in Buckinghamshire, and I can give her some information on that. First, I remind her that provider arms are not allowed to be commissioners of services. Secondly, unless I misheard the hon. Lady, she said that a budget had been handed over to a practice PCT by Buckinghamshire NHS. My information is that it has not had a budget handed over to it, but it is advising on a sub-committee of the PCT on an indicative budget in a traditional, practice-based commissioning arrangement. It has to get PCT approval for any spend. I hope that that helps the hon. Lady. However, if on reflection she wants to come back to me at a later stage—I suspect she will not have the time to reflect on it today—I would be more than happy to respond. If I can help her, I will.

Moving on, I listened with interest to the points that the hon. Lady made about a two-tier system. It will come as no surprise to her that I do not share her analysis of the situation. I do not think that a two-tier system is arising or about to arise over the next two years or so.

At the moment, while pathfinders are working with PCTs, learning the way and finessing their expertise and experience for the challenges and the work that they will do after they get full control of commissioning for their patients, there will be movements at different paces. That is perfectly reasonable and does not automatically mean that there is a two-tier system. I will pray in aid an organisation that I know finds favour with the hon. Lady; no doubt she will respect the views of Professor Chris Ham.

When asked about this, Professor Ham said:

—Pace needs to be judged according to the ability of the new clinical commissioners to take on the responsibilities being offered to them. I could point you to some parts of the country in which the GPs, because they have been in the pathfinders, are almost ready to go. Why would we hold them back? There are some excellent examples around the country, but there are many others, often next door, where that is not the case. So pace has to be judged in relation to the ability of people to take on the responsibilities being put in their direction.”—[Official Report, Health and Social Care Public Bill Committee, 28 June 2011; c. 24, Q55.] I think that that is a very reasonable assessment not only of the situation but of the way we should move forward. There always will be different levels of movement forward; it will not be uniform across the country throughout the pathfinders. It would be most unnatural if it was.

I do not think that the situation will develop into the sort of problem that the hon. Lady mentioned. I should also add, as a kind of check against a two-tier system developing, that clinical commissioning groups are being helped at the moment by working with PCTs. They will also get help and assistance from the NHS commissioning board in due course. That, to me, is a block against a two-tier system developing.

The hon. Member for Leicester West also mentioned probity. I certainly do not believe that GPs will be influenced by money. The core motivation and driving force of a GP is to look after their patients and do what is in their best interests. Doctors are a deeply committed group of people, as are nurses and others who work in the NHS. It is unfair and unrealistic to suggest that GPs will start putting bank accounts and money ahead of the interests of their patients; they are too committed and too professional to get wrapped up in that sort of thing. I do not think that the hon. Lady should worry about that, because I do not think that it is fair on doctors.

5.15 pm

I will leave it at that, because I do not want to get into another argument with the hon. Lady on an issue that has caused some controversy in the Committee. I would also like to say, as a back-up to that, that doctors already have codes of conduct in their royal colleges about their behaviour and motivation—how they look after patients and carry out their duties—and I am confident that those are a brake on the sort of situation she describes arising.

Finally, my hon. Friend the Member for Stafford mentioned the comments made by our right hon. Friend the Secretary of State during his evidence earlier this week. The answer to my hon. Friend’s question is yes. I hope that helps, and in that spirit, I urge my hon. Friends and the Committee to support clause 6.

Liz Kendall: The hon. Member for Southport rightly mentioned the perennial challenges of the need both to involve clinicians in wider decisions and to make sure that they always put patients’ interests first, I was not confused about the three issues that I raised—fears about two tiers, fears about conflicts of interests and fears about rationing. I realise that they are different; I was simply trying to cover them all.

At the heart of the debate is our concern that something different is going on here. My hon. Friend the Member for Oldham East and Saddleworth highlighted some interesting evidence about QOF and the impact that that has had. This is something different, because clinicians will be taking on the commissioning of a wider range of services. It is not only about good management of their own budgets; they are taking on a different role. Bodies
and people including GPs themselves have voiced concerns about what that would mean, and it is right that Opposition Members raise those concerns here, as part of our scrutiny of the Bill.

On the point about NHS Buckinghamshire, if I got the facts wrong I will blame Pulse magazine, which reported that NHS Buckinghamshire had devolved budgets for commissioning out-patient appointments and prescribing to a private company called The Practice plc. I would like the Minister to write to me to state whether that is the case and what safeguards would be in place to deal with such circumstances.

Mr Burns: I am more than happy to do that for the hon. Lady.

Liz Kendall: Thank you very much. I am grateful that both Ministers—one of them is not here—have always written to me when they said they would.

I would have liked the Minister to have been stronger in saying not that the idea of drawing up an explicit list of services to be rationed does not find favour with him, but that he would rule it out in the Bill. When we discuss later clauses, I will explain why I think the Government do not rule that out.

Question put and agreed to.

Clause 6 accordingly ordered to stand part of the Bill.

Clause 9

DUTIES OF CONSORTIA AS TO COMMISSIONING CERTAIN HEALTH SERVICES

Mr Burns: I beg to move Government amendment 57, in clause 9, page 6, line 3, after ‘for’, insert ‘—

(a).

The Chair: With this it will be convenient to discuss the following: Government amendments 58 and 59.

Mr Burns: The amendments are to new subsections (1A) and (1B), which are to be inserted in section 3 of the NHS Act 2006 by clause 9. I should emphasise that the amendments do not constitute any change in the policy intentions of the Bill. The amendments will achieve what we had intended to achieve with secondary legislation, and the Bill as originally drafted and scrutinised by Parliament would have achieved this, but in response to the concerns raised during the listening exercise by the NHS Future Forum and by professional organisations, we recognise that there would be value in clarifying on the face of the Bill the responsibilities of clinical commissioning groups. This should leave no doubt in the minds of the future commissioners about the scope of their responsibilities and, more importantly ensure that there is no apprehension among the public that there are gaps in the responsibilities of those with whom we intend to entrust the co-ordination, planning and securing of the care we receive from the NHS. In that sense, the changes are significant in ensuring the coherence of the Bill and that we maintain the trust of professionals and public alike in the NHS.

The amendments are intended to clarify the responsibilities of clinical commissioning groups in two important areas, which I would like to consider in turn. First, amendments 57 and 58 make it clear that a clinical commissioning group has responsibility for commissioning care not only for patients who are registered with a GP practice included in the membership of the commissioning group, but for people usually resident in the area covered by the clinical commissioning group who are not registered with a GP practice.

Owen Smith: Will the Minister define precisely what he means by “usually resident in the area”?

Mr Burns: I will return to that later, but if the hon. Gentleman thinks that he has caught me on the hop and he wants an instant answer, I will give him one that immediately springs to mind: students usually live in an area, but go away for part of the year to university, college or whatever. I will come on to that in more detail with some other groups later, but I hope that that helps.

A strong message from the NHS Future Forum was the importance of ensuring that the new arrangements for commissioning recognise the need for a system within which services are delivered with the objective of health improvement across the whole population. There were concerns that that would be undermined if it appeared that clinical commissioning groups did not have a clear duty to the whole resident population. The forum reported that “the responsibility for commissioning services for a defined geography and population is, we believe, particularly important to ensure that people are covered by health and other local services in an integrated way, and for a Population Health perspective to be effective.”

On a similar theme, concerns have also been raised by important stakeholder organisations such as the Royal College of General Practitioners that the Bill as drafted did not make it clear that clinical commissioning groups had responsibility not only for their registered patients but for those who are not registered anywhere with a GP, a category which often includes vulnerable and hard-to-reach groups—I imagine the hon. Member for Pontypridd will want to listen to this—as homeless people, Travellers or refugees. There was a strong view that the particular health needs of such groups should not be overlooked, however inadvertently. The amendments, as part of our wider drive to remove inequalities and improve outcomes, make sure that that cannot happen.

There are likely to be instances where clinical commissioning groups are specifically not to have responsibility for certain people who would otherwise meet the criteria. That could include, for example, people who are receiving primary medical services as temporary residents, such as someone on holiday in an area covered by a clinical commissioning group who was registered with another GP elsewhere in the country. The regulation-making power in new subsection (1C) would allow such exemptions to be made and give us the flexibility to divide categories of patient among those who are not registered with a GP and for whom the clinical commissioning group does not have responsibility, which might include some categories of overseas visitors, who are usually eligible to be charged for the hospital care that they receive.

Amendment 59 makes it clear that we intend to specify in regulations that a CCG also has responsibility for ensuring that it commissions emergency services to meet the reasonable requirements of anyone in the area that it covers. That might include ambulance and accident
and emergency services and other urgent and emergency care services such as walk-in centres. It was always our intention to make that a responsibility through secondary legislation, and that has not changed. It would be far more inflexible and impractical were we to specify those responsibilities on the face of the Bill. However, we are making it clear in the Bill that the regulations that we intend to make under the powers must capture that responsibility, to remove any doubt that clinical commissioning groups are responsible for ensuring that everyone who needs emergency care has access to it.

That does not, of course, affect any current rules on charging. The proposed amendment would not prevent the NHS from subsequently charging overseas visitors who receive emergency care if they are eligible to be charged. I emphasise also that the amendments do not refer to access to primary medical care, which will be commissioned by the NHS commissioning board. To be clear, the amendments will not change the nature of entitlement or access to primary medical care services.

On Tuesday, Andrew Cozens, an adviser to the Local Government Group, highlighted concerns that the proposed amendments miss wider responsibilities. The example that he gave was of emergency mental health services or services for homeless people. Homeless people in the area covered by a clinical commissioning group are in fact covered by the amendments if they are not registered with a GP practice. On Mr Cozens’ first point, it would not be appropriate to list specific responsibilities in detail or make specific provision for so-called Cinderella services. We cannot feasibly or flexibly cover all potential services; in particular, we cannot make prescriptions in primary legislation that might cut across the autonomy of commissioners and their partners on health and well-being boards to identify local demand and commission accordingly. None the less, I accept the important point that commissioning must be thorough in detecting local need, and the service provided must be comprehensive to meet those needs. I do not doubt that the framework that we are endeavouring to put in place does so.

We have tried to strike a balance in the amendments between clarifying on the face of the Bill the responsibilities of CCGs and retaining a degree of flexibility to ensure through regulations that we have the scope to adapt as necessary policy on urgent and emergency care and entitlement charging, or to meet our EU obligations. For those reasons, I urge Committee members to accept the amendments.

The Chair: Before I call the next speaker, let me say that I consider it highly unlikely that there will be a stand part debate on the clause, so I am prepared to accept comments that go slightly wider than the amendments, on the strict understanding that those comments relate to clause 9 and not other clauses.

Emily Thornberry: I am grateful to the Minister for some of the points that he has made. I listened with interest to his answer to Andrew Cozens, the witness from the Local Government Association. It is yet another example of the great mistake that the Government are making in rushing the Bill through the parliamentary process. Mr Cozens was given an opportunity to discuss just one of his three concerns, and that was it. I am pleased that the Government appear to have responded to his point, but I have only heard what the Minister has just said. I now have to go away and read his comments, and we have to speak to Mr Cozens. We would like to come back, but we will not be able to because of the timetable that the Government are pushing on us.

It is unfortunate because we want to try to improve the Bill—if we cannot defeat it—and we need the opportunity to be able to work properly and constructively. Frankly, it is very difficult, but I know the Minister’s response to that. It is a shame that the witness did not have the opportunity to voice his other two concerns. The Government may have risen to the challenge on Mr Cozens’ first concern, although I am not sure yet, and there could have been an opportunity for them to rise to his other two challenges, too.

5.30 pm

Amendment 58 would insert a reference to “persons who usually reside in the consortium’s area and are not provided with primary medical services by a member of any consortium.”

There is a question about what that “usually” means and where the definition is to be found. Although the Minister criticises some Opposition Members for not listening when he is listing people who might fall within a consortium’s area, the fact is the list that he was reading out is the one that we gave him in the previous Committee proceedings.

Mr Burns: You must be pleased.

Emily Thornberry: I would like to say that I am pleased, but given the way in which partial quotations are used, from the Prime Minister downwards, I have to wonder whether, in future, the rest of this sentence will be read out, too: in the narrow confines of this particular section of a bad Bill, I am pleased that that part of a bad Bill is now better, and in that context, I am pleased that the Government have listened to us—to that extent. Please, though, do not pray that in aid of any claim that there have been substantial or substantive changes to the Bill. It is but a tiny corner of it.

Grahame M. Morris: In that spirit of goodwill and magnanimity, will the Government acknowledge that we were right and they were wrong? [Interruption.]

Emily Thornberry: Unfortunately, Hansard will not be able to record the mass cheering that broke out at that point. I think I heard from Government Members, “Yes, you were right. We’re very sorry”—[Laughter.]

Mr Burns: You’re pushing it.

Emily Thornberry: I definitely remember the Minister saying that the amendments we tabled last time were unnecessary, but it is better for a sinner to come back, and so on. I have nothing more to say on amendment 58.

Amendment 59 deals with the confusion raised by Andrew Cozens and the possible partial movement on the part of the Government, which I am pleased about, as a result of his evidence. I remain concerned, as does he and the LGA, about Cinderella services and exactly
what will happen to those. I heard the Minister when he said that he felt that he cannot list them all, but the difficulty is that it is that much more important to be clear about who provides such services because they are exactly the sort of services that will be overlooked by GP commissioning consortia.

I am also concerned about the continuing confusion over who will commission ambulance services. Will they be commissioned locally or regionally? We still do not really understand. I do not know whether there have been substantial and substantive changes to the Bill sufficient for that now to be clear. I suspect not. In those circumstances, it is difficult for us to be entirely confident about amendment 59, which refers to “the provision of services or facilities for emergency care”, because we do not know whether that includes ambulance services. Without an answer to that, it is very unsatisfactory that the Committee is being asked to agree the amendment when have not been given a clear idea about an important part of emergency care, which ambulance services clearly are.

I am also to a certain extent unclear about what the Government will do about boundaries. The Future Forum report states:

“If a commissioning group wishes to be established on the basis of boundaries that would cross local authority boundaries, it will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefits for patients: for example, if it would reflect local patient flows or enable the group to take on practices where, overall, this would secure a better service for patients. Further, they would need to provide a clear account of how they would expect to achieve better integration between health and social care services.”

On Tuesday, the Secretary of State said that “through the authorisation process, those 16—and others, if they wish to have a boundary that crosses the unitary or upper-tier authority’s boundaries—will need to explain and justify that by reference to the benefit to patients. Indeed, they will need to show that if they do that, they have got clear mechanisms in place to secure continuing integration between health and social care.”

Where is the amendment that deals with that? Where is the amendment that deals with the important issue of coterminosity? At the very least, it should be made clear that GP commissioning consortia must stick to local authority boundaries, but where are the changes apart from warm words? Where are the changes in the Bill that will make a difference in coterminosity? We are concerned about that clearly important issue. Everyone seems to be singing from the same page when it comes to the importance of integrating health and social care, but that will not have a chance of success if GP practices have to look after an area that includes two local authority areas. That would make the provision of services too difficult for everyone. Integration is hard enough without putting more boundaries in the way.

We tabled an amendment to delete clause 9, although it was not selected for debate. There is a reason why we did that and why we have grave reservations about the clause, in addition to the points that I have raised about the drafting of the Bill and what is and is not covered. We had a long debate about the role of the Secretary of State, his powers and what he is and is not in charge of, but there is even more concern about the Secretary of State’s responsibilities as amended when they are compared with the provisions in clause 9, which seem to contradict the Secretary of State’s powers as debated this morning. I do not understand how the two sit side by side.

The clause will give consortia the power to decide what services will be part of the NHS. If it is to be commissioning consortia that make those decisions and one of them decides that peeling bunions should not be part of the menu of services available to people, what will the Secretary of State do about that? How does he relate to that? How can he overturn a decision made by a commissioning consortium under the provisions of clause 9? There seems to be an essential contradiction.

That is part of what I was trying to say earlier: pushing powers away from the Secretary of State and trying to pass responsibility on to bodies will come back to bite the Government. If those other bodies exercise the autonomy that the Government seem to wish to give them, decisions may be made on rationing, or on not giving access to particular things and on saying, “You can have that only if you pay,” or, “We will write out a list of what we are prepared to give, but here is a list of things that you will have to pay for.” How can we hold commissioning consortia to account? We cannot hold the Secretary of State to account for it.

Dr Poulter: Is there not a similar situation at the moment with PCTs? At the moment, the health care lottery is an established phenomenon. We have seen arbitrary rules set up by bureaucrats, often against the wishes of medical professionals on the ground who may want to help individual patients. Will not the proposed system be a better way of enabling GPs and health care professionals to engage and meet the needs of individual patients?

Emily Thornberry: I hear what the hon. Gentleman says and I doubt that this will come as a surprise to him because, as has already been said, many of the arguments have been taken around the block by the Committee. I think he knows that many, if not all, of us believe that there should have been changes to the primary care trusts—but changes are one thing; abolition is something else. There is an issue about PCTs not being sufficiently responsive or democratic, and we heard what the Liberal Democrats’ policy was before the last election, although it is not their policy now. How to make primary care trusts more democratically accountable was an area of live debate, but we should not simply get rid of them and put in their place GP commissioning consortia that have no democratic accountability. There is no such accountability in the make-up of the consortia, and the contradictions in the Bill’s early clauses push the Secretary of State’s control over them further away. It is a matter of real concern.

Dr Poulter: The point is that, time and again, PCTs and strategic health authorities make decisions very much against the advice of medical professionals on the ground and democratically elected local representatives. Few mechanisms are available to people in local areas to challenge the decisions of PCTs effectively. I do not follow the hon. Lady’s argument.

Emily Thornberry: From my own experiences and, I am sure, that of others, I am aware of many times when we as elected representatives felt that our PCTs were not
sufficiently responsive to what we thought our local electorate wanted. I find it ironic that I spent many years trying to persuade my PCT to listen to what I was saying, because I was a democratically elected representative of my area, and then, at my first meeting with it after the present Government were elected, it asked me to help save it. However, I do not know of any examples—if the hon. Gentleman has any, I would be grateful to hear them—of GPs saying that they needed to spend money on the care of individual patients and the PCT not allowing that to happen.

Dr Poulter: I will give a hospital example. PCTs often have a lot of funding for fertility services and access to them. At the moment, the guidelines are arbitrary in different parts of the country and there is a huge postcode lottery. Hospital doctors and fertility experts would like to treat the patient according to the relevant clinical criteria, rather than have to deal with the arbitrary criteria imposed by the PCT. Funnily enough, those fertility experts are experts in their field.

Emily Thornberry: That is a good point, well made. In relation to GPs, however, I think that the problem will be magnified rather than diminished. To fix a problem, do not make it even bigger. That is not the way to do it.

Grahame M. Morris: I am rather surprised by the comments of Government Members. My interpretation of the clause and of the Government’s amendments is that it is a postcode lottery clause. Inevitably, whether by accident or design, the proposal will bring about variations in service. For example, in my own area, chronic obstructive pulmonary disease is considered a priority, and probably rightly so, but there is a variation in the provision that does not exist in any other part of the region. Some may think that that is a good thing and that it is by design, or they may think that it is a bad thing, but it certainly leads to a variation in services. The situation is a postcode lottery.

Emily Thornberry: I know that at one stage one interpretation of the Bill was that if an individual lived outside the usual area of a GP commissioning consortia, they would be able to sign up to one in an area in which they did not live. If that remains the case, the problem that the hon. Member for Central Suffolk and North Ipswich raised could be exacerbated 100 times, because if one GP commissioning consortium in Aberdeen was providing fertility treatment, I am quite sure that infertile couples up and down the country would all sign up for that consortium. If one GP says, “I am no longer going to provide that service under the national health service, thank you very much,” what is a constituent to do? Can they, for example, complain to their Member of Parliament? Can that Member of Parliament raise that with the Secretary of State? Does the Secretary of State have any power over the GP commissioning consortia?

Mr Burns: I will give the hon. Lady two answers. She asked earlier about where in the Bill were the powers, when she was discussing coterminosity, and they are in clause 21, new section 14C(2)(c) of the 2006 Act. She just asked another question, and she will be aware that CCGs cannot arbitrarily exclude services; they must base their decisions on clinical need, among other factors. The Secretary of State and the NHS commissioning board are under a duty to promote a comprehensive health service and can use their functions to undertake that, as the mandate and the outcomes framework determine.

Emily Thornberry: A question clearly arises from that. If GPs are going to be making decisions on the basis of clinical need “among other factors,” we need to know what those other factors are.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): I want to return to the term “usually” in amendment 58. Although my hon. Friend brought up the example of Aberdeen, which is a devolved matter, is there anything to stop a Scottish resident from registering with an English consortia?

Emily Thornberry: I have no idea. As I say, the changes to the Bill have been brought in at short notice, and we are doing our best to catch up. Frankly, however, when the Secretary of State does not know the details of clauses 1 and 2, what are the chances for the rest of us?

Grahame M. Morris: On the same question, is there anything to prevent health tourism, where somebody registers with a particular clinical commissioning group, because it has a particular expertise in a particular field? Would multiple registrations be permitted?

Emily Thornberry: I hope that the Minister is making a note and will be able to answer these questions. These are all valid and live questions that deserve an answer.

Mr Burns: Ludicrous.

Emily Thornberry: I am insulted that the Minister thinks they are ludicrous. If I was unfortunate enough to be part of an infertile couple, I would do anything to get access to fertility treatment. If it meant registering in one end of the country, and if my husband then developed a rare form of cancer and I felt that a GP in Cornwall could offer a treatment that I thought might help, I would register there as well, given half a chance. That is the truth. I do not think that is ludicrous; I think that is possible.
Mr Burns: What I was saying was ludicrous was the concept, not the highly emotive and, in real life, tragic situation that the hon. Lady described; no one would describe this as too ludicrous. There were some fishing around for circumstances that are highly unlikely ever to happen, just to make a debating point.

Emily Thornberry: We are not.

Mr Burns: The hon. Lady may not be, but the hon. Member for Easington knows what I am talking about.

Emily Thornberry: I know that the right hon. Gentleman is an experienced Member of the House, but I feel as though his Whip roots really come out at times in a way that is very unfortunate. The purpose of our being in the Committee and asking questions is to scrutinise the legislation, and to look at it from all angles. We are doing our job, and frankly I think we are doing it rather well. The more irritated the Minister becomes, the more confirmed I am in my view that we are doing it well.

Grahame M. Morris: As we have heard, clause 9 transfers the functions of arranging provisions listed under section 3 that were previously vested with the Secretary of State to the clinical commissioning groups. They will not have a duty to provide or secure that provision except to the extent that they consider it necessary to meet reasonable requirements.

That is particularly significant for the care of pregnant women, women who are breastfeeding, young children, other services or facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness. In terms of those responsibilities, it is now for each of the clinical commissioning groups to determine what is appropriate as part of the health service. They are being given the discretion to determine that within the limits of the measure.

As I mentioned in an intervention, my concern is that that could give rise to a postcode lottery situation. The Bill gives the commissioning boards a duty to ensure that services are provided through its functions to the consortia, with specific services left to local determination. A lack of a direct relationship seems to make the Secretary of State's duty to secure provision of services extremely limited.

I turn to the Government amendments. I welcome that they have acknowledged some of the issues raised, not least by Opposition Members, during the listening exercise. We raised the matter about the Secretary of State delegating his responsibilities to the commissioning board and to the consortia, and we also legitimately raised the issue about conflicts of interest and variations in service. In addition—the following matter comes into the postcode lottery category—we pointed out the risks of private providers cherry-picking elements of the service and issues of accountability and coterminosity.

Opposition Members and stakeholders, not least in representations that Members have received, have asked about the issue of coterminosity between the clinical commissioning groups and the local authority. There will be coterminosity between the clinical commissioners and the health and well-being boards.

It seems that we have a halfway house because, as the Bill stands, the clinical commissioning consortia commission care for patients who are registered with member practices rather than for a geographical population. Government amendments 57, 58 and 59 change the position, leaving consortia responsible for “persons who are provided with primary medical services by a member of the consortium”.

That is rather different. Perhaps the Minister can explain why they did not just refer to everyone who lives in the clinical commissioning group's area. This is not sophistry; there is a difference in meaning with that choice of words.

One of my hon. Friends asked the Minister to give some examples of groups that would be covered by amendment 58, under which the consortia have additional responsibility for “persons who usually reside in the consortium's area”.

I can clearly identify students, and perhaps homeless people and members of the travelling community. These people are provided with primary medical services by a member of the consortium that makes up the clinical commissioning group. In other words, these people are usually in that geographical location but are not registered with a GP. Many students fall into that category.

Fiona O'Donnell: I understand why Government Members believe that the straw-man accusation might surface again, but the issue is a real concern. There are parallels with the passage of the Scotland Bill and definitions of Scottish taxpayers. It is important that the Government provide clarity before the Bill progresses.

Grahame M. Morris: I am grateful for that intervention. The wording in the clause has implications. I do not want to be pedantic, but one issue is funding. I am aware that the proposals fall far short of changes anticipated by, for example, the Social Liberal Forum. In its analysis of the proposals, it called for “Local commissioning bodies to have responsibility for clearly defined geographical populations and to be funded on the basis of relative need as now.”

You can imagine, Mr Gale, that some categories of people and some constituencies have many students—for example, in Manchester and the big cities. If that is not factored into their capitation funding allocation, the impact on the local economy will be significant.

[Interruption.] The Minister is looking quizzical, and perhaps he will clarify the position.

An issue that is dear to the heart of some Labour Members and, I hope, on the Government Benches—my hon. Friend the Member for Oldham East and Saddleworth raised it—is the implication for addressing health inequalities. Clearly, if a needs-based allocation does not reflect the true population, there would be implications for the clinical commissioning group's ability to commission relevant services.

There are some inconsistencies. Some issues were raised, by accident or by design, and there are questions to be asked. There should have been an easier way of reconciling. Why define for emergency care, but not for all primary care? That seems bizarre.
The change is substantial—and confusing, because patients may find their care commissioned by different bodies as they move from the accident and emergency department to a ward, or when they are discharged into the community. It is understandable that that might happen if someone is working away from home or is away on holiday and has an accident.

As I mentioned, it would be hard to allocate funding according to population needs, because the population would not necessarily resemble the wider demographic mix of the geographical area covered, and I suspect that that may become worse over time. The approach does not fit with the gist of the Future Forum's recommendations. During our evidence session, it was specific about what it wanted, and page 10 of its workstream on patient involvement and public accountability states:

“We heard many views about the importance of co-terminosity of commissioning consortia with the boundaries of local authorities and health and wellbeing boards. The responsibility for commissioning services for a defined geography and population is, we believe, particularly important to ensure that people are covered by health and other local services in an integrated way, and for a Population Health perspective to be effective.”

I am also worried that when collecting an evidence base, the impact of the 30% in-year cuts to the public health observatories—

6 pm

Debate interrupted (Programme Order, 28 June).