Public Bill Committee

HEALTH AND SOCIAL CARE
(RE-COMMITTED) BILL

Fifth Sitting
Tuesday 5 July 2011
(Morning)

CONTENTS
Written evidence reported to the House.
CLAUSE 19, as amended, under consideration when the Committee adjourned till this day at Four o'clock.
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The Committee consisted of the following Members:

*Chairs:* †Dr William McCrea, Mr Jim Hood, Mr Roger Gale, Mr Mike Hancock

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

† Morris, Grahame M. (Easington) (Lab)
† 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 Secretary of State will consult on the revisions. The mandate will be updated annually and include other factors, such as the spending review cycle. The amendments are a response to concerns raised during the listening exercise, particularly the British Medical Association. We intend the mandate to allow the board to plan effectively over the medium and long term. Where possible, we want the mandate to cover a three-year period, although that will depend on their terms of reference. Amendments 65 and 79, therefore, remove the requirement for the mandate to specify the cash allocation for the board.

The amendments relate to the Secretary of State’s mandate to the commissioning board and I will address them thematically, starting with amendments 60, 62 and 64. Amendments 60 and 62 make it clear that the Secretary of State’s mandate to the commissioning board will be a multi-year document, rather than be issued afresh each year. The amendments are a response to concerns raised during the listening exercise, particularly by the British Medical Association. We intend the mandate to allow the board to plan effectively over the medium and long term. Where possible, we want the mandate to cover a three-year period, although that will depend on other factors, such as the spending review cycle.

To ensure that all relevant developments are accounted for in it, the mandate will be updated annually and the Secretary of State will consult on the revisions. The mandate may then be changed only by agreement or in exceptional circumstances. Any changes must be published and laid before Parliament with an explanation for the change.

Fiona O’Donnell (East Lothian) (Lab): The Minister says the Secretary of State will consult. Who will be included in that consultation?

Mr Burns: It will be a general consultation so that the Secretary of State can get the views of the NHS, relevant individuals within the health economy and others. Amendment 64 is about involving patients and the public. The Future Forum emphasised the importance of involving patients and the public in decision making, which we strongly support. We tabled the amendment to make it explicit that, in setting the mandate for the board, the Secretary of State must consult HealthWatch England.

The remainder of the amendments in this group relate to financial matters affecting the board. Amendments 61, 63 and 66 will require the Secretary of State to specify annually, as part of the mandate, the capital and revenue resource allocations that will be made to the board under the amendments proposed to clause 20. Under standard Government accounting practice, spending allocations and spending limits are framed in terms of the use of resources, to take account of spending commitments that fall across a number of financial years; it is therefore the primary means by which budgets are set in the NHS. The Secretary of State’s ability to alter those resource limits will continue to be restricted: he will be able to alter them only with the board’s agreement in exceptional circumstances. If he does so, the mandate will need to be revised and laid before Parliament, along with an explanation for the change.

The amendments will remove the requirement for the mandate to specify the cash allocation for the board. That is because the board’s cash allocation in a given year will be dependent on its resource commitments and its spending plans for the coming year against the limits set in the mandate. The board’s cash allocation and related limits on cash expenditure will therefore be more difficult to predict at the time the mandate is published, and will be more likely to change for perfectly legitimate reasons.

Amendments 65 and 79 reflect the revised time scale we have set for the establishment of the commissioning board following the listening exercise. As we set out in our responses to the listening exercise, the commissioning board will be established as a non-departmental public body next year in order to begin the establishment and authorisation of clinical commissioning groups, but it will not take on its full financial responsibilities until April 2013. It is therefore no longer necessary to make special provision for the period up to the start of the first full financial year in which the commissioning board operates. Amendments 65 and 79, therefore, remove subsection (9) of new section 13A and subsection (5) of new section 13O of the National Health Service Act 2006, inserted by the clause, to reflect the fact that the first mandate and the board’s first business plan will be for the period beginning April 2013.

The amendments will make practical changes necessary to follow through commitments made by the Government in response to the Future Forum report and I urge the Committee to accept them.
Liz Kendall (Leicester West) (Lab): It is a pleasure to serve under your chairmanship, Dr McCrea.

I have a series of questions for the Minister about the amendments, their purpose and objectives. I hope that he will be able to answer today but, if he cannot, that he will write to me.

If we are to have the system the Government propose—I preface my remarks with that—it is a good idea to have the mandate that the Secretary of State gives the board cover more than one year, to give the NHS board and the NHS as a whole the ability to plan longer term. It is also right that the board will consult HealthWatch on the mandate, although we have already raised concerns about the degree to which HealthWatch will be independent, but does HealthWatch have to agree to the mandate? Will its view on the mandate be published and made freely available? Does the board have to respond publicly to any concerns or views raised by HealthWatch?

My second set of questions relates to when the NHS board is to be established. According the Government’s response to the Future Forum, the NHS commissioning board will be established part way through 2012-13, but its first mandate and business plan will relate to 2013-14. What will the board do in the intervening year? How will Parliament hold the board to account? If the board’s first mandate from the Secretary of State will be for 2013-14 but the board is established the year before, what will it be doing and how will it be held to account for its actions by Parliament?

Mr Burns: Will the hon. Lady give way?

Liz Kendall: If the Minister lets me finish my series of questions, he will see where I am going with this.

As the right hon. Gentleman will be aware, several organisations, including the NHS Confederation, have raised concerns about the role of the board in the interim, before clinical commissioning groups are up and running. It will be commissioning services for clinical commissioning groups that are not yet ready to take on their responsibilities and it will obviously be going through a process of authorising those groups, but I am not clear how Parliament will hold the board to account if it does not get its first mandate until a year after it has been established.

What will Parliament’s role be in scrutinising the mandate? During the previous Committee debates, the Minister told my hon. Friend the Member for Islington South and Finsbury that Parliament will get a chance to discuss the mandate. Will he confirm that that will take place annually? Will Parliament be able to vote on the mandate? Will the mandate be scrutinised by the Select Committee on Health or the Public Accounts Committee? Simply publishing the mandate is insufficient; Members of Parliament should be able to discuss and scrutinise it.

My third series of questions is about the amendments that now make it clear that the Secretary of State has to specify capital and revenue within the overall allocation to the board. That is standard Treasury practice, so unless I am mistaken—which I may well be—why did the Government not think about that the first time around? Why are they now tabling a series of amendments to specify the capital and revenue allocations to the board and stating that the board will have to do the same for consortia? What discussions did the Department have with the Treasury about that? Why has it taken the Government so long to realise that that is part of the Treasury’s standard accounting practice?

Mr Burns: To deal with the last question first, the straightforward answer is because we spent more than eight weeks listening and consulting on how to strengthen and improve the Bill, and we decided in the light of that exercise that here was an opportunity to make improvements and to strengthen the Bill. That is why we are doing this now.

The hon. Lady asked whether HealthWatch would have to agree to what is in the mandate. The answer is no. She asked whether the response of HealthWatch would be published. That is not required, but it can publish if it wishes to. She asked whether the board would respond publicly to what HealthWatch said. The answer is no, but the standard practice is to respond to the consultation, so one can assume that, as part and parcel of the consultation exercise as a whole, there will be a published response.

The hon. Lady asked about accountability, but I will leave that for now and return to it when I discuss accountability of the commissioning board, because in some ways it is part and parcel of the same answer.

The hon. Lady asked what the commissioning board will do from October 2012, when it is set up in shadow form, and particularly what it will be doing in financial year 2012-13 before it becomes fully established in April 2013. As she knows, the board will be established formally as an independent statutory body by October 2012 to start to authorise clinical commissioning groups and carry out preparatory functions. The purpose of having the board in place in shadow form for a long period is to provide clear leadership and capacity for the development of the new commissioning systems. The chief executive designate of the NHS commissioning board, Sir David Nicholson will set out how the role of the board is developing, although final decisions will be taken by the board itself once it is formally established. It will be accountable to the Secretary of State for the functions that it exercises during that period.

The hon. Lady asked why the Bill does not require Parliament to approve the Secretary of State’s mandate to the board. We have discussed that before, but let me try to reassure her. The process of setting the mandate is already transparent and accountable and sits within the wider framework of increased parliamentary scrutiny. For the first time, the objectives will be developed transparently through public consultation; the Secretary of State is required to consult the board, HealthWatch England and other appropriate persons. We are proposing an amendment to include HealthWatch England specifically in that consultation process, because of the responses that we received from the Future Forum, to ensure that arrangements for patient, carer and public involvement are not only genuine and meaningful, but built into all levels of the health and well-being system. The mandate may be changed only by agreement, as she knows, or in special circumstances. Any changes have to be published and laid before Parliament with an explanation of the reasons for the change.

Not only must the board publish its plans for how it intends to meet the requirements of the mandate, but it must report at the end of each year on how it has performed. The Department of Health then has to set
Mr Simon Burns: Out its own assessment of the board’s performance and lay that before Parliament. To my mind, and I hope the hon. Lady agrees, that all strengthens accountability to Parliament and to members of the public for how taxpayers’ money is spent and what is delivered in return.

10.45 am

There will be a significant number of opportunities within the parliamentary process for bodies to be held to account for that information, those actions and those duties. For example, they can be debated in Parliament. The hon. Lady asks whether there will be a vote; that depends on the motions and the procedures used in Parliament to debate them. For example, the Government could—I use the conditional tense because we are so far away that I do not know the answer yet—have a stand-alone debate on those matters either on a motion for the Adjournment which, as the hon. Lady knows, would not require a vote at the end, or on a substantive motion, which would.

Similarly, the Opposition of the day would—could—be able to hold an Opposition day debate, after which there almost certainly would be a vote because the Opposition would table a motion in such a way that there would be a vote unless the Government of the day agreed with their motion. There can be other debates which, depending on the forum, could lead to a vote. There could be an hour-and-a-half debate instigated by a right hon. or hon. Member in Westminster Hall, which would not require a vote; or a debate on the Floor of the House could be granted by the Backbench Business Committee, which, I understand, is keen that such debates should take place on a substantive motion that leads to a vote.

Other opportunities for holding to account, either for the matter in its entirety or for individual aspects of it, are Health questions, Adjournment debates whether at the end of the evening on the Floor of the House or in Westminster Hall, and other questions. The opportunities for parliamentary scrutiny and accountability are immense and should meet the concerns of all hon. Members.

Let me expand on Parliament’s role in relation to the commissioning board in 2012-13, when it is in its shadow form and getting ready to perform its functions from April 2013. The hon. Lady asked how the board will be held to account during that period. Apart from what I have said, because there is nothing to stop questions being asked in Parliament during that period, Parliament will be able to hold the board to account for its work through the usual ways that I have described. The Health Committee, which the hon. Lady mentioned, can call anyone to give evidence and can hold hearings on any aspect of the Department of Health and the NHS, so, yes, it will be able to hold inquiries into the commissioning board and call in evidence from the relevant people on the mandate, the commissioning board and the NHS in general.

Liz Kendall: I have some other comments to make when the Minister has concluded, Dr McCrea, but at this stage I would simply like to ask him about the money that is allocated to the board and for which it will have responsibility during its shadow period. How much money will the Government give the board to do its work in 2012-13 and how much money will the board itself be responsible for? The Public Accounts Committee will be very concerned about that, as it is responsible in Parliament for determining whether Government money is properly spent.

Mr Burns: I understand that. My straightforward answer is that at this stage it is premature to put pound figures to those sums. I will seek advice to see whether there is anything more helpful that I can give her. If I can, I will.

To conclude on that point, Sir David Nicholson, who, as the hon. Lady knows, is the chief executive of the NHS and the chief executive designate of the commissioning board, will already at that stage be the formal accounting officer for the commissioning board. He can be held to account as such in that role, which makes him accountable for the commissioning board.

I have just been given a note, which I hope will help the Committee. On the question of the money, I am right; I cannot give the hon. Lady a definitive figure at this stage, because it is too soon. I can tell her, and I hope it helps, that there will be only a limited budget, as the board will not start commissioning until the financial year 2013-14.

Liz Kendall: I thank the Minister for clarifying the role of Parliament in debating the mandate. That was helpful, and I am sure that hon. Members will already be thinking about the various debates and motions that they will call and move. There are some clear issues here, however. First, it is astonishing, particularly in the current economic climate, that the Government do not know how much money they will be giving to the NHS commissioning board to fund its work in shadow form in 2012-13.

Mr Burns: If the Minister wants to intervene, I am happy to let him. He said that it would be premature to give a figure. We are talking about next year; it should not be premature.

Mr Burns: I want to clarify what I said so that it does not become a misnomer, for which the hon. Lady has, at times, been famous. What I said was that it was difficult at this stage and premature to give the hon. Lady a definitive figure. I said that she had to bear in mind that there will be a limited budget only as the commissioning will not commence until 2013-14. That puts the whole situation in a slightly more realistic perspective than what the hon. Lady is suggesting that I said.

Liz Kendall: I disagree. The Minister says he cannot give a definitive figure. Hospitals, primary care trusts and GPs are being given definitive figures about how much they can spend, but the national commissioning board is not. He says that the budget will be limited, but limited to what? Will it be £10 million, £20 million or £140 million, like Monitor? Perhaps he would like to give me a rough estimate.

Mr Burns: No, however charming the hon. Lady is, I will not be dragged down the route of illustrative examples à la A and E; the Committee can see that I am still scarred by that experience.
Liz Kendall: I perfectly well understand that the board will not commission its own services or allocate money to primary care trusts to do so, but I want to know whether it will employ people. What other roles will it take on? How much money is being spent on the NHS commissioning board? It is astonishing that the Government do not have even a rough estimate of how much that is going to cost or how they will be held to account for delivering it by the Public Accounts Committee. That is a major gap in the Government’s proposals. I think the Treasury would be interested to know that they have no idea how much the shadow national board will cost to run.

If the Minister wrote to me to specify the precise functions that the shadow NHS commissioning board will have in 2012-13, how many staff it will employ and how it will be held to account by Parliament, including by the Public Accounts Committee, we might have greater reassurance that the Government have got a grip on the Department’s spending.

I should be grateful if the Minister specified where in the Future Forum response people are clamouring for the precise allocations of capital and revenue for the board and the consortia. He said that the Government did not include such measures in the previous legislation, but they have spent eight weeks listening and that is what people told them they wanted. I may be wrong, but I cannot remember reading in any of the Future Forum reports that a major concern with the Bill was to be used to commission care through the primary care trusts. That is why the commissioning board will not be getting the money during that period, and why it is difficult at this stage to give a definitive answer about how much it will be given.

Mr Burns: Good try. In her charming way, the hon. Lady is beginning to make heavy weather of this. She must understand that during the listening process it was not only the Future Forum going out and meeting all kinds of people in the NHS and the health economy to get their views, but Ministers as well. Ministers continued to meet other people to discuss and reflect on how to strengthen and improve the Bill. The hon. Lady’s point about the finances flowed from that. We concluded that it was an area in which we could improve the measure, and it was obvious that we should do so after the listening process, because the Bill was to be recommitted, which gave us an opportunity to strengthen it in a wide range of areas. It is no big deal. It is simply an improvement.

Liz Kendall: I asked if the Minister could give any example of people in the Future Forum saying that. My hunch is that it was the Treasury. I am not saying that that is a bad thing, but he should make it clear.

I am grateful to the Minister for clarifying the fact that HealthWatch, which is supposed to be the national voice for patients, does not have to agree the mandate that the Secretary of State gives the board—so much for, “No decision about me, without me.” I hope that the NHS board publishes HealthWatch’s views and its response to them. That is convention, but I am glad the Minister has put it on the record.

Mr Burns: May I help the hon. Lady on another point to save my writing to her? She keeps asking when we will know when the allocations will be ready. I said to her, and it remains the case, that it is premature at this point to give an answer. However, as she knows, the board will be established as a special health authority later this year, and once it is established and its operational structure develops, we will have a clearer idea of its operating costs and so on at that point. I hope that is helpful. I know the hon. Lady will like this: we will provide a revised impact assessment as the Bill leaves the House and goes to another place, so she will find an answer to her questions then.

Liz Kendall: I am glad the Minister is attempting to show that he has a grip on the process. The Government said that they were determined to cut the costs of bureaucracy, but they do not even know the costs of one of the biggest quangos they are creating. I find that astonishing. He has dug himself into an even greater hole; he said that the board would be set up as a shadow board next year.

Mr Burns: I said later this year.

11 am

Liz Kendall: With the greatest respect, the Minister said that the board will be set up in October 2012. Unless spending so much time in this wonderful Committee has meant that I have lost a year of my life, October 2012 is next year. I would be grateful if the Minister clarified that. That is why I am pressing the Government. NHS organisations, which are trying to make huge savings with tight resources, will find it astonishing that the Government have given themselves incredible leeway on the costs of the board.

Mr Burns: The hon. Lady is being a little unfair. What I have said during the debate is perfectly consistent and straightforward but, because it involves two years with the same month of October, she may be a bit confused. I said that the NHS commissioning board will act in shadow form as a special health authority from October 2011 and, subject to parliamentary approval, it will be established as a non-departmental public body by October 2012. I said that earlier in the debate. I am repeating it now. I hope that that ends her confusion.

Liz Kendall: It may well have ended the Minister’s apparent earlier confusion, and I am grateful for that, but my fundamental point remains the same. It is astonishing that we are setting up the board in special health authority or shadow form when we do not know what the costs will be or how it will be held to account.
[Liz Kendall]

I have one final question for the Minister. Once the board is set up as a non-departmental public body from October 2012, it will start to authorise clinical commissioning groups. Is the Minister saying that no clinical commissioning group will be authorised before October 2012? I wonder if he can answer that question. No. The Minister is not able to answer. He said that the board will begin to authorise clinical commissioning groups in October 2012. If the Minister cannot say whether any clinical commissioning groups will be authorised before then, they will not be, so none will have any devolved budgets or responsibilities before then.

Mr Burns: No.

Liz Kendall: That is interesting, considering a report that I mentioned to the Committee last Thursday—the Minister said that he would write to me about it, but I have not seen that letter yet—which says that some clinical commissioning groups have already had budgets devolved to them. I am therefore grateful that the Minister has clarified that point.

Amendment 60 agreed to. Amendments made: 61, in clause 19, page 15, line 8, leave out from ‘mandate’ to end of line 13 and insert ‘the amounts that the Secretary of State has decided to specify in relation to the financial year for the purposes of section 223DA(2) and (3) (limits on capital and revenue resource use).’

Amendment 62, in clause 19, page 15, leave out lines 15 to 20.

Amendment 63, in clause 19, page 15, leave out lines 21 to 27 and insert—

’(a) any proposals that the Secretary of State has as to the amounts that the Secretary of State will specify in relation to subsequent financial years for the purposes of section 223DA(2) and (3).’

Amendment 64, in clause 19, page 15, line 40, at end insert—

’(b) the Healthwatch England committee of the Care Quality Commission, and.’

Amendment 65, in clause 19, page 15, leave out lines 43 and 44.

Amendment 66, in clause 19, page 16, line 1, leave out from ‘State’ to second ‘the’ in line 2 and insert ‘varies the amount specified for the purposes of section 223DA(2) or (3).’

Mr Burns: I beg to move amendment 67, in clause 19, page 16, line 15, at end insert—

13BA Duty to promote NHS Constitution

(1) The Board must, in the exercise of its functions—

(a) act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and

(b) promote awareness of the NHS Constitution among patients, staff and members of the public.

(2) In this section—

“health services” means services provided as part of the health service;

“patients” and “staff” have the same meanings as in Chapter 1 of Part 1 of the Health Act 2009 (see section 3(7) of that Act).’

The Chair: With this it will be convenient to discuss Government amendment 108.

Mr Burns: Before I speak to the amendments, I want to reiterate to the hon. Member for Leicester West that there is a letter coming to her as a result of our debates last Thursday, and I hope that it will be with her, if not later today, then certainly tomorrow. I hope that she will find it helpful.

I do not want to deal with the amendments at length. The Government have always made clear their support for the NHS constitution and its principles, responsibilities, values and rights, including the right to receive NHS services free of charge and the right to make choices about NHS care and to information to support those choices.

The NHS Future Forum was united in its support for the enduring values of the NHS and the rights of patients and citizens set out in the NHS constitution. It was concerned, however, that awareness among patients and the public of their rights is low. It recommended that the Bill be amended to include new duties for the NHS commissioning board and clinical commissioning groups actively to promote and raise awareness of the NHS constitution and the rights that it enshrines.

As the hon. Member for Halton (Derek Twigg) noted in Committee in February:

“...It is right that we should enshrine the primacy of the NHS Constitution up front and ensure that the Bill makes it explicit that its commitments shall be upheld in new legislation.”—[Official Report, Health and Social Care Public Bill Committee, 15 February 2011; c. 185].

The amendments do just that. They place new duties on the board and CCGs requiring them, when exercising their functions, both to act with a view to securing the provision of health services in a way that promotes the NHS constitution, and to promote awareness of the NHS constitution among patients, staff and members of the public. That means not only would they need to have regard to the constitution and promote awareness of it, including making people aware of their rights, but they would need to act with a view to securing health service provision that promotes the principles, rights, responsibilities and values of the constitution. That may be through their own actions, but also through facilitating the actions of stakeholders, partners and providers.

For example, CCGs and the board must consider how to build the constitution into their work on patient and public involvement. The board could also discharge the duty by highlighting areas of the constitution of particular relevance to the content of the commissioning guidance that it can issue to clinical commissioning groups under new section 14V of the 2006 Act. The new duties will be additional to the existing duty under the Health Act 2009 to “have regard” to the NHS constitution, which will be applied to the board and CCGs by virtue of the amendment made to the Health Act at paragraph 167 of schedule 5 to the Bill.

The Government have made clear their continued commitment to the NHS constitution, and the intention that the board would promote awareness of the NHS constitution across all NHS-funded services. We have accepted the Future Forum’s recommendation that the board and the important role that clinical commissioning groups play in relation to the NHS constitution need to be made explicit in the Bill.
Liz Kendall: I am very pleased that the Government have now listened to people’s real concerns about the Bill. If they had listened to us in the last Public Bill Committee—when we tabled amendment 43, which said that the board should promote the principles and values of the NHS constitution—they might have saved themselves and, more importantly, patients and NHS staff, a great deal of bother.

I am proud that the previous Government, in the face of many people’s cynicism, went ahead with developing the NHS constitution. I might have misunderstood him, but I think the Minister said that it had cross-party support. It was the Labour Government who initiated the constitution; we led the work with patients, the public and members of staff. I pay tribute to the former Secretary of State, my right hon. Friend the Member for Leigh (Andy Burnham), for taking that important initiative.

The Government should have listened to us. That they now have to ensure that the NHS constitution is in the Bill shows how extraordinarily worried people have been about their plans. We have had many debates about the strength of different words, such as act “with a view to” or “with regard to”. Last week in Committee, the Government admitted that the duty of the Secretary of State to deliver a comprehensive health service was not strong enough in the original Bill, so they removed some phrases such as act “with a view to”. We still do not think that they have gone far enough, but they have removed those words in an attempt to strengthen the duty. Yet amendment 67 states that the board must “act with a view to securing that health services are provided in a way which promotes the NHS Constitution”.

The Government have to choose one way or the other—either the wording of the Bill matters and needs to be strong and clear, or it does not. It is a pity that the Government’s amendments are not stronger. More importantly, there is the practical question of how we will know that both the board and the clinical commissioning groups are doing what they are supposed to be doing. How will we know that they are acting with a view to securing services, promoting the constitution and promoting awareness of the constitution?

I want to give a specific example. The NHS constitution introduces a clear right to non-emergency treatment within a maximum of 18 weeks. The other day, the Prime Minister made much of saying that he will not let waiting lists rise, but we know that the number of people waiting longer than 18 weeks for treatment has started to rise. We debated that last week. Unfortunately, you missed it, Dr McCrea; I am sure you are sorry about that. The Government claimed that average waiting times were falling, but they did not address the issue of those waiting more than 18 weeks, which is what the NHS constitution is about.

Written evidence submitted yesterday by the Patients Association outlined clear evidence that waiting times are rising for many patients. The number of calls to its helpline, from patients and health care professionals concerned about access to elective surgery, has risen considerably between 2010 and 2011. The Patients Association has reported that, in the first six months of this year, concerns about waiting times for elective surgery represented 18% of the calls to its helpline, which is more than double the proportion in 2010.

Is the Department of Health still collecting data on the number of patients waiting more than 18 weeks for elective treatment by clusters of primary care trusts and by hospital trusts? If the Department is not collecting that information, how do we know whether waiting lists are starting to rise? Are waiting lists a target, or not? Are trusts being performance managed to ensure that they hit those targets? It is all very well for the Minister to say that the constitution is enshrined in law, but if no one is collecting the data and no one is performance managing the system, how do we know that the numbers are not starting to rise?

Mr Burns: This may prevent the hon. Lady from detaining the Committee for some considerable time. The straightforward answer is, of course, that we are collecting the data on median times and on how many people are waiting for how long. Nothing has changed.

Liz Kendall: The Minister says, “Of course we are collecting data on median times”—

Mr Burns: And the number of people.

Liz Kendall: —“and the number of people”. Will the Minister make it clear whether the system is being performance managed to hit those targets? I know he wants to zip through this stuff, but I am trying to figure out whether this amendment will make any difference to how long patients wait.

Secondly, how will we know that the board and the consortia are effectively promoting the constitution? Will the board or consortia fund campaigns to increase awareness among patients, the public and staff? If so, how much will those campaigns cost? How will they practically ensure that patients, the public and staff know about their rights? Are they going to survey them? If so, will they publish the results of those surveys? How much will those surveys cost? This is about not only changing the wording of the legislation, but making it real to people. I have yet to hear an explanation from the Government on how any of these provisions will work on the ground.

11.15 am

Mr Burns: The hon. Lady raises both an interesting and a rather important point. We believe, as the amendments reflect, that it is important that patients, individuals, patient groups, and so on, are familiar—far more familiar than they may be now—with the NHS constitution, because we think it is extremely important. Effectively, it has to be ensured that people become aware of it. Part of that, I am afraid, will be an educational process, because far too many people have been unaware of the NHS constitution since it came into place: that is partly why the amendments would create a duty to promote it.

The hon. Lady asked how that would happen. To give the background, the amendments are designed to place an additional legal duty on the commissioning board and the CCGs to promote the constitution, by requiring them to exercise all their functions, and to act “with a view”—/Interruption./ The hon. Lady should—she has changed her mind. I thought she was being quizzical.

Liz Kendall: I was scratching my chin.
Mr Burns: I shall give her the benefit of the doubt. There would be a duty to promote the constitution by requiring the commissioning board and CCGs, when exercising all their functions, to act "with a view" to securing that health services are provided in a way that promotes the constitution, and it would be required that awareness of the constitution be promoted among patients, members of the public and staff. For example, that would include making patients aware of their right under the constitution to access services within maximum waiting times, or the NHS taking all reasonable steps to offer a range of alternative providers if that is not possible.

We would therefore expect that if someone has waited for 18 weeks, the NHS, at local level, will ensure that alternative providers are offered to honour that pledge, so that patients get the treatment they require. It could be done through commissioning arrangements with providers, and through the commissioning board’s commissioning guidance for CCGs. In that way, we believe that the Bill will reinforce and strengthen the enduring values and principles of the health service. It will fully embed the constitution in how the NHS works, empowering patients and the public.

The hon. Lady asked about how this would look in practice. As patients were made aware of their right under the constitution to access services within maximum waiting times, more patients would become aware of it; I suspect that they would exercise that right, because they would know what they were entitled to. The NHS would then have to respond.

Liz Kendall: Will the Minister guarantee that the Department will continue to collect and publish all the data on the waiting times guarantee set out in the NHS constitution?

Mr Burns: The waiting times guarantee?

Liz Kendall: The NHS constitution contains clear rights for patients on a number of different waiting time targets. Will the Minister guarantee that the Department of Health will continue to collect those data for every area and trust within the NHS?

Mr Burns: What I can tell the hon. Lady is that either the Department of Health or the national commissioning board will continue to collect those data.

Liz Kendall: Will they publish it?

Mr Burns: What we publish now and what has always been published, will, to the best of my knowledge, continue to be published. One of the other pillars of NHS modernisation is ensuring more information and greater transparency within the workings of the NHS. If we want people to be able to exercise choice, they have to be empowered with information and knowledge. The hon. Lady is making a bit of a heavy meal of this, because we publish statistics every month about what is happening in different areas of the NHS.

Liz Kendall: I do not intend to make a heavy meal of anything. The Government said that they would scrap all targets. Now that they are back in, I want to guarantee that we will know how many people have long waits for their treatment—otherwise, the duty to promote the NHS constitution is worthless.

Mr Burns: First, we did not say that we would scrap all targets. What we said was significantly different from that statement. [Interruption.] The right hon. Member for Rother Valley laughs—I am surprised that only he did, because I was waiting for it. We said that we would not keep politically motivated targets, but that any target with a clinical justification, such as the cancer target, would be kept. [Interruption.] There is not much more to say; this is quite definitive.

Liz Kendall: What is politically motivated about a target that means people do not have to wait longer?

Mr Burns: I am surprised that the hon. Lady, given her history at the Department of Health at the height of the operation of such targets, does not know the answer to that question.

Fiona O’Donnell: Will the Minister give way?

Mr Burns: Let me answer the hon. Member for Leicester West first. The answer to her question is straightforward: politically motivated targets are ones that are imposed with no clinical justification whatever. They are imposed by politicians to ensure a political result for political ends.

Liz Kendall: That is completely wrong and unfair. Our targets were about achieving what patients wanted, which was not to have to wait. People experienced huge waits in A and E and huge waits for their operations—they were waiting more than two years for operations in 1997. I do not want to get into a huge other debate, but I want it on the record that when we were in government, our targets were about improving care for patients, not about some political goal.

Mr Burns: My immediate reaction is: “so sensitive”—I have obviously struck a nerve. The Government have contended that the previous Government distorted treatments and clinical decisions by medically qualified people by introducing a plethora of politically motivated targets, rather than imposing targets for clinical reasons.

Emily Thornberry (Islington South and Finsbury) (Lab): Will the Minister give way?

Mr Burns: No, because I have been debating this matter with the hon. Member for Leicester West.

Emily Thornberry: I was listening carefully—[Interruption.] I come alive? The whole debate has been alive—we have had an intelligent debate so far.

Emily Thornberry: Will the Minister give way?
Mr Burns: No. The hon. Lady can make her contribution if she catches Dr McCrea’s eye.

In conclusion, I say to the hon. Member for Leicester West that we are, and always have been, in favour of more information. We are committed not only to publishing the data that we collect, but to opening them up to third parties through the Information Centre. The public will not only have the Government’s interpretation of the information, as they have in the past, but be able to make up their own minds about it. We have no desire or intention to limit the information, so people will be able to judge the performance of the NHS both nationally and locally. I urge my hon. Friends to support the amendment as part of that process.

Emily Thornberry: I shall be brief, Dr McCrea. Clearly, the national health service and its future is an important issue. I am concerned about the sloganeering that one hears during elections, which is repeated on doorstep, being the basis for making serious policy changes to the national health service. I am forced to get to my feet because the Minister continues to bandy around such phrases as, “We’ve got rid of politically motivated targets.” That may sound good on the front pages of the Daily Mail, but can he come up with any examples? I suspect that he knows that I wanted to ask that, which is why he would not allow me to intervene.

Fiona O’Donnell: Thank you for calling me to speak, Dr McCrea. It is a pleasure to serve under your chairmanship.

I have not had the advantage of my hon. Friend the Member for Leicester West—I was not at the top of the NHS under the last Government—but I have been a patient. Again, I ask the Minister to give the Committee an example of how the issue will affect patients. The constitution can seem like a distant mission statement to many patients, but what, more than anything else, breathed life into the constitution and empowered patients was the waiting time guarantee.

The Minister has still to give us an example of a politically motivated target that did not benefit patients and of what his evidence was for making that statement. I also ask him to reflect on a contribution to the previous Bill Committee—on which, unfortunately, I did not serve. Stephen Thornton spoke about the benefits of guaranteed waiting times, in terms of not just people getting their treatment more quickly, but the evidence that it drove up standards generally.

Mr Burns: I wanted to intervene earlier on a point that the hon. Lady made with some justification. Unfortunately, the improvements that the Bill will bring to England will not have any impact on people in Scotland because, as she is aware, health is a devolved matter for the Scottish Administration.

Fiona O’Donnell: The Minister may not be aware that sometimes people who live in Scotland have previously lived in England and enjoyed the benefits of health services delivered by a Labour Government. I am lucky to have been one of those people, so I had direct experience. But I will forgive the Minister. I would much rather have an answer to my substantive question about the targets that were set that were not of benefit to patients.

Owen Smith (Pontypridd) (Lab): Will my hon. Friend give way?

Mr Burns: Oh, Wales.

Owen Smith: Does my hon. Friend agree with my understanding that this is still a British Parliament? The fact that she is a Scottish Member and I am a Welsh Member is entirely irrelevant because our job here is to scrutinise legislation as it applies right across the UK. It ill behoves the Minister to keep coming up with these little Englisher comments.

Fiona O’Donnell: Absolutely—and not just little Englander, but even shouting out “Wales” and “Scotland” as we rise to our feet. A great number of my constituents in East Lothian contacted me about the Bill. It may not directly impact on them, but it will impact on their families and their friends. They know that I will vote on this Bill and they care not just about people in Scotland, but about people across the UK.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): It is fair to say that targets are a crude mechanism for driving down waiting times. That can be a good thing. However, would the hon. Lady accept that there is a problem with targets? Very often with the arbitrary A and E waiting targets, setting a four-hour wait time means that someone with potentially serious symptoms becomes a lower priority than someone who is closer to that four-hour wait time. That is a clinical experience and the reality in many A and Es because many patients end up being bypassed from A and E to an admissions unit without being seen by a doctor.

Fiona O’Donnell: First, the crude is often the more effective way of dealing with a problem, in that it directly impacts on patients and they can see the benefits. It does not need a Bill or a constitution; it is about a culture and working with those targets. I do not agree with the hon. Gentleman’s evidence about A and E waiting times. [Interruption.] I will give way to the Minister because I sense that he is becoming more irritable.

Mr Burns: I am not irritable at all. I am in a good mood, although in passing I point out that I was amused when the hon. Lady took an intervention from a Member from a Welsh constituency. Welsh waiting times under a Labour Government in Wales are over 18 weeks and are going up significantly because they are cutting the year-on-year funding to the health service. Returning to the point about targets, the hon. Lady has to understand that if targets are politically rather than clinically motivated and imposed, no attention is paid to the outcomes. That is crucial. Politically imposed targets are driven by politicians’ views of where the health service should be, rather than giving clinicians the choice and the judgment to determine how to treat patients.

Fiona O’Donnell: The Minister is easily amused, but he still has not given us an example of a politically motivated target. Surely, politics is about deciding what
is right and what is wrong. We say that it is right to make sure that no one waits longer than 18 weeks for treatment.

**Emily Thornberry:** I do not know whether my hon. Friend has had the experience that I and a number of my constituents have had of waiting for four hours in A and E with a sick child. I am surprised that not all clinicians know that four hours in A and E with a sick child is a complete lifetime, and that it is only responsible to ensure a maximum waiting time of four hours in A and E for mothers.

**Fiona O’Donnell:** I thank my hon. Friend for her intervention.

**Dr Poulter rose—**

**Fiona O’Donnell:** I will not take another intervention. I look forward to the Minister giving us one concrete example of a target that did not benefit patients, given that patient satisfaction increased under the previous Government. That is what really matters, more than anything else.

**Owen Smith:** Of course, we respect the hon. Gentleman’s experience as a clinician. However, is he seriously telling the Committee that doctors in A and E departments up and down the country prioritise children with stubbed toes—[Interruption.] With respect, that is precisely what he said. The example given was that “every day” doctors prioritise minor ailments—stubbed toes—over children with a life-threatening disease or condition, as a result of the target. Friends of mine who are doctors would dispute that and find it incredible to hear it suggested.

**Dr Poulter:** I am not suggesting that, given the choice between two patients immediately in front of them, doctors will choose the one with the broken toe over one with asthma. The problem is that the four-hour wait distortion means that the patient with a stubbed toe has to be seen within four hours, as a clinical priority, ahead of patients with potentially more serious conditions. That happens day in, day out. I could take members to any A and E where that will be happening, right here and now. If we went over the river to St Thomas’ hospital, that is what we would see.

**Liz Kendall:** Will the hon. Gentleman give way?

**Emily Thornberry:** Will the hon. Gentleman give way?

**Dr Poulter:** No, not at the moment.

Because some patients are not treated effectively due to demands on services and the four-hour target, a lot of patients are often rushed from A and E, almost in a by-pass mechanism, to emergency medical units. Their “box of care” is effectively ticked, but the proper treatment is not instigated. Patients who may or may not be admitted are often by-passed through A and E and go on to an emergency medical unit without necessarily receiving the important care they need, because of the existence of a four-hour target, which distorts priorities. I could take members to any A and E in the country and that would be happening, right here and now today.

**Liz Kendall:** Like my hon. Friend the Member for Pontypridd, I have listened to the hon. Gentleman’s views because of his experience. Does he agree that overall, the targets introduced into A and E have transformed the experience of many patients over the past 13 years, and that before, they had to wait far longer? Does he admit that, although many doctors would say that there might be problems around the edges, overall the target has helped transform A and E services for patients?
Dr Poulter: The hon. Lady makes a fair point, which I made at the beginning. The targets are a crude mechanism for improving standards; that is right. Targets did help drive down times waiting to be seen; I am not contesting that. It is a good thing that patients are seen more quickly. The problem is that an arbitrary target for the number of patients who need to be seen within a certain time—everyone has to be seen within four hours—affects medical professionals’ ability to use their clinical judgment to prioritise who needs to be seen when and where. That is the point that we are making. Those are politically driven targets, and they get in the way of clinical priorities.

Of course, there is a crude mechanism whereby targets can be effective. However, an obsession with targets developed in the NHS over the past few years—Mid Staffordshire was a good example—has got in the way of medical professionals treating the patients in front of them. What matters in health care and medicine is treating patients according to clinical priorities. Targets have prevented many doctors from doing that.

Mr Kevin Barron (Rother Valley) (Lab): Will the hon. Gentleman give way?

Dr Poulter: I will give way one final time in one moment. Patients certainly need to be seen in a timely manner, but we cannot allow targets to misrepresent clinical priorities and interfere with patient care, as has been the case.

Mr Barron: In the last Parliament, I took evidence concerning people who were officially responsible for the Mid Staffordshire hospital scenario. Given that there is now a public inquiry, we would do better to wait to see the final outcome. The idea that that situation was about waiting times in A and E is nonsense. People who had deep responsibility for patients were ignoring that responsibility, in my view.

Dr Poulter: I thank the right hon. Gentleman, but the first report into Mid Staffordshire nevertheless highlighted the fact that an obsession with process, ticking boxes and meeting targets was one of the fundamental problems. We are not just specifically discussing the A and E target. What matters in medicine is looking after patients; it does not necessarily matter what the targets are. The patient needs looking after. Far too often in health care, there is so much bureaucracy and paperwork and so many targets that clinical priorities are distorted. That was admitted by my hospital in Ipswich recently, which had a poor Care Quality Commission report into elderly care, and it meant that elderly patients were not being properly looked after. The generic issue of targets was shown in the earlier reports into Mid Staffordshire to be part of the problem, and I hope the right hon. Gentleman will accept that.

Mr Barron: No, I won’t.

Dr Poulter: I accept that that is the right hon. Gentleman’s view, but the report makes that point clearly. I will not say much more, Dr McCrea, but the point remains that we need to allow, and the priority must be to allow, medical professionals to look after patients according to clinical priorities. While targets have a useful purpose, they must never be allowed to distort high-quality patient care according to clinical judgment.

Emily Thornberry: The hon. Gentleman raised the issue of a child with a broken toe. I will enlighten him—as a mother speaking to a clinician—that my daughter broke her toe at the age of nine, and we went to University college London hospital. She waited for three and a half hours to see a doctor, by which stage both of us were in a heck of a state. Her foot had swollen up, and she was in a great deal of pain. The hon. Gentleman mentions people being seen in a timely manner, but frankly, for her to have waited for over four hours would not have been timely, and the Labour Government were doing the right thing by ensuring that we had a four-hour cut-off. People had to be seen within four hours.

The Chair: At the beginning of the debate on the amendment, I was very impressed by the consensus between the Front Benches. Things have livened up a little bit, and we are, therefore, having exciting debates.

Amendment 67 agreed to.

Liz Kendall: I beg to move amendment 3, in clause 19, page 16, line 18, at end insert—

‘13CA Duty as to commissioning of services
In carrying out its duties in respect of the commissioning of services the Board must in the exercise of its functions have regard to the interdependency of services and the impact that the arrangements for the provision for one service may have on the financial and clinical sustainability of other services’.

The Chair: With this it will be convenient to discuss amendment 6, in clause 22, page 30, line 6, at end insert—

‘14KA Duty as to commissioning of services
In carrying out its duties in respect of the commissioning of services each commissioning consortium must in the exercise of its functions have regard to the interdependency of services and the impact that the arrangements for the provision for one service may have on the financial and clinical sustainability of other services.’.

Liz Kendall: Amendments 3 and 6 would prevent cherry-picking—the hon. Member for Enfield North asked where the debate on that issue would come—in the NHS.

During the previous Committee, we had several discussions about whether the Government’s NHS plans would increase the likelihood that private providers could select easier, more profitable cases and leave the NHS to deal with more complex and expensive conditions.

That real concern was raised, as the Minister will know, during the Government’s listening exercise, and within the context of a Bill that seeks to promote competition throughout all parts of the NHS, that seeks to let any willing or qualified provider come into many parts of the system, and that currently allows Monitor to say to hospitals, GPs or other services, “I’m afraid that you have to let your facilities be used by the private sector in order to create a level playing field.” The Minister will be coming to amendments on such issues later on, so I will not go into them in detail here, but suffice it to say that we will scrutinise them closely.
11.45 am

Cherry-picking is an extremely important issue. If I may, Dr McCrea, I will report several conversations I had with chief executives of NHS trusts who were involved in the different parts of the Future Forum. Privately, so I cannot say who they are, they raised concerns directly with me that not only private providers, but GPs would choose to deliver various out-patients’ appointments, dermatology clinics and perhaps even cataract surgery—high-volume, relatively straightforward and cheap services—in their clinics, which would mean that hospitals were left to treat the patients with much more complex conditions. They explained that trusts often use those high-volume, low-cost services to fund the more complex parts of their hospitals, namely A and E, so they were extremely concerned that if more such services were shifted out, either into the private sector and/or into GPs surgeries, it would threaten the financial stability of hospitals. Being hospital executives, perhaps they were likely to say this, but they told me that although they understood the need to move care out of hospitals and close to people’s homes, they were keen for GPs to concentrate a little more on providing out-of-hours services, so that people did not end up at A and E in the first place, which costs the overall system more.

The Future Forum and hon. Members during the previous Committee, including the hon. Member for Stafford, who is unfortunately not here at the moment, raised the fact that private providers are not required to provide education and training for the future NHS. Opposition Members tabled an amendment about training, because it is vital that all parts of the system help to provide education and training for the future NHS, not only because that is fair, but particularly if they deliver more services under the Government’s plans, not only because that is fair, but especially if they deliver more services under the Government’s plans, not only because that is fair, but because it is vital that all parts of the system help to provide education and training for the future NHS work force.

Margot James (Stourbridge) (Con): The hon. Lady has been bundling up the issues. The fact that private providers and/or GP practices can perform routine procedures better out of hospital must be a good thing. The future of our health care service is to provide more routine procedures out of hospital and for more complex procedures to find their home in hospital. That is the future for quality of care, patient satisfaction and saving money.

We must go down that route. Surely it was within the commissioning power of PCTs to arrange for such contracts to be commissioned more sensitively and cleverly, rather than in the bulk manner that was their habit. The whole ethos behind clinical commissioning is to improve the standard of commissioning so that we can realise the benefits of care being delivered closer to home.

Liz Kendall: I thank the hon. Lady for that intervention, but such decisions have consequences for hospitals, such as the hospital in her constituency, and might ultimately bring the financial sustainability and viability of hospitals into question. If we move services out of hospitals, eventually staff go, links to other services are lost and potentially wards close. There will be an impact on hospitals. I am not suggesting that we do not need to look at services—in fact, I am a passionate and long-standing champion of moving care out of hospitals and into the community—but there are consequences of doing so. That issue was raised with me as we listened, as we always do, during the pause. Opposition Members still have concerns about what the Government say they will do to prevent cherry-picking. Although we are not considering Government amendments, I will discuss that now to explain why we have tabled amendments 3 and 6.

Our first concern is about the tariff. I am sure the Government will say, as they did in their response to the Future Forum, that they want a tariff that fully reflects the different costs of providing a particular service, such as hospital readmissions and aftercare, so that it reflects the full complexity of services, including those provided within the community. That is the right way for the tariff to operate, but I want hon. Members to be aware of, that of the £105 billion spent on the NHS, some £30 billion—I might easily be wrong, but the Minister will correct me if I am—is covered by tariff. It has taken us six or seven years to develop a tariff for that proportion of health care funding, all of which relates to hospital services.

That £30 billion does not cover every aspect of hospital services, but it covers 70% or 80% of them. We still do not have tariffs for mental health services provided within hospitals and so on, or for £75 billion of health care spending on the more complex provision. We have nothing on community services, for example, which is where we need to shift our focus if we are to improve care and deliver better value for money. It will take us a long time to get for all parts of the NHS a tariff that fully reflects the care costs of people along a pathway. It is right to say that the tariff needs to reflect costs fully, but it will take us a long time to get there. In the meantime, how will the Government prevent cherry-picking, as they have asserted they will? That is the context of our amendments.

Secondly, we will come on to this, but the Government have tabled a subsequent group of amendments requiring providers of services to specify the criteria they use to select the patients they are willing to accept or treat, and to publish those criteria. The Government say that those requirements will prevent cherry-picking, but they will not prevent providers from selecting or choosing patients; it just means they will have to be more open about it. Why do not the Government simply say instead, “You have to take any patient who is referred to you.”? That is what happens with NHS services now, so why not in future?

That is a long way of saying that I am not convinced that the Government’s amendments on cherry-picking will be enough. They are not enough now, and they will take a long time to become enough, hence our tabling amendments 3 and 6, which state that when the commissioning board or commissioning consortia commission services, they must have regard to what we call the interdependency of services—the impact that any change in the provision of a service may have on other services—in terms of their financial and clinical viability and sustainability.

Bodies that are responsible for commissioning services must understand the effect that moving provision to a different public sector, private sector or voluntary sector provider may have on the financial sustainability of a hospital from which the service is being moved; they
need to understand the impact and implications of their decisions. A fundamental flaw of the Bill is the lack of a requirement on anyone to look at the health economy as a whole to understand the impact that changing services will have, whether it is out of hospitals and into the community or between public and private providers. MPs need to be aware of that, because such measures will affect every single hospital in every single constituency. Unless the national board and clinical commissioning groups are aware of that, changes will happen that may have unintended and very real consequences for patients. There is no requirement anywhere in the Bill for people to take that into account. Amendments 3 and 6 will help to ensure that cherry-picking does not happen and that somebody has an overview of the impact on our local health economies, which is what ultimately matters to our patients.

Mr Burns: As the hon. Lady said, these linked amendments seek to place duties on the commissioning board and clinical commissioning groups. While I understand the intention behind them, they would be impractical as primary legislation. Their aim is to ensure that decisions to extend choice about the provision of services do not destabilise existing services in terms of their financial viability or—perhaps even more important—their clinical safety. It is not necessary to create additional duties, because those factors are a key part of good commissioning.

The underlying principle of the Bill is to require commissioning boards to secure the best possible care for patients. The fundamental duty of the NHS commissioning board will be to promote a comprehensive health service. The NHS commissioning board will hold this duty concurrently with the Secretary of State, and clinical commissioning groups will be required to arrange for the provision of health services for their populations. Furthermore, the Bill creates additional duties on CCGs and the NHS commissioning board in relation to securing high-quality integrated care that will deliver value for money for local communities and promote opportunities for patients to exercise choice in relation to their care. In taking commissioning decisions, they will therefore have to consider what will be in the best overall interest of their patients. This would always be their primary concern. I appreciate that concern has been expressed about how far they will have the freedom to do this.

The Government acknowledged in their response to the report from Future Forum that we have not clearly enough described the role of commissioners in leading the choice and competition agenda. We recognise the concern that Monitor could have more control over local services than local commissioners. That is why we have tabled amendments to clause 56, which, as the hon. Member for Leicester West very fairly commented, we will be discussing in detail when we come to them. The amendments will change Monitor’s duty so that it no longer refers to “promoting competition”, but instead to “promoting provision of health care services which—

(a) is economic, efficient and effective, and

(b) maintains or improves the quality of the services.”

We are clear that competition should not be an end in itself, but should be a means of improving choice in the quality of services for patients. In line with Future Forum’s recommendations, we remain firmly committed to the presumption of choice as a key part of our vision of an NHS that puts patients first. However, we have made it clear that the commissioning board will set the choice offer, based on the choice mandate that the Secretary of State will set as part of the annual mandate to the commissioning board. This would cover more than just choice provider. As Future Forum said, “Choice is much more than the ability to choose a different provider of elective surgery. It is also about the choice of care and treatment, the way care is provided and the ability to control budgets and self-manage conditions.”

Where choice is extended, a range of providers will offer services, otherwise the choice offer would be meaningless. The Government are committed to a level playing field. Providers must be treated on a non-discriminatory basis, and processes must be transparent. However, the key point is that this is a commissioner-driven process, and we will ensure that providers will not be able to cherry-pick patients.

12 noon

Amendments on the national tariff, which we will debate in the context of clause 115, and a proposed new clause requiring providers to publish their eligibility criteria, which we will consider when we reach clause 101, will help ensure that that is the case. We also want to ensure that the national tariff does not tie the hands of local commissioners. That is why the tariff could include rules, which would have to be agreed between Monitor and the NHS commissioning board, setting out circumstances in which commissioners could vary the specifications or prices in the tariff.

Furthermore, the amendments we will come to in clause 22 will ensure that planned changes to local services are based on genuine engagement with the public, and are in line with the joint health and well-being strategy. They will, of course, also continue to be subject to local democratic scrutiny. For the commissioners who drive the process, this is their job as already set out in the Bill. The amendments would create an unnecessary legislative duty with the potential to confuse their primary purpose, which is commissioning in the best interest of patients. For that reason, I hope that my hon. Friends will reject the amendments if they are pressed to a Division.

I seek your advice, Dr McCrea. The hon. Member for Leicester West asked how to stop cherry-picking. We shall come to the main debate about cherry-picking on other clauses, but, if it is any help, I have a list of measures that will help prevent it. Dr McCrea, you may think it more appropriate to discuss those and share the list at another time, when we come to the relevant clauses. If you feel it would help the Committee to have the list read now, I am happy to do so.

The Chair: If the Minister feels that it would be helpful, he could read it out briefly now. If it is going to be at length, then it will have to be at a later time.

Mr Burns: It is quite a long list. I am grateful, Dr McCrea. In the light of the helpful advice from the hon. Member for Leicester West, it will be more appropriate to do so when we come to the main amendments.
John Pugh (Southport) (LD): It would not be a disaster if the amendment were agreed. However, it is redundant. Everybody is against cherry-picking and agrees it is a bad thing. Everybody takes the point that the hon. Member for Leicester West made about the dangers of a private or voluntary provider moving into high-volume, low-risk simple services. We saw in previous years that the private sector was happy to come into areas such as treatment centres, where it treated joints with no real complications that had no effect on the respiratory or the cardiac system. It did the simple work, motivated to do so by the previous Government. We all recognise that some of the simple services depend on back-up if things go wrong, which is provided normally by the local district general or specialist hospitals working in the complex fields.

I slightly disagree with my hon. Friend the Member for Stourbridge, who suggested that there could be a simple scenario in which the local DGH concentrated on the complicated and difficult, leaving the simple and obvious to the private sector. Although such a system could easily function without any complications, it would have a ripple effect. I can give a simple example: a popular field for the private sector to compete in is dermatology. One of the complications of dermatological problems can be cancer. A lot of the dermatological private enterprises do not do cancer, but none the less will come across symptoms that will require reference to a cancer specialist. One could look at a happy scenario in which the private sector got on with the simple stuff and the local specialist hospital got on with the more complicated stuff. The more likely outcome, if the private sector, by whatever means, entirely takes the simple stuff off the hospital, is that the cancer specialists at that hospital depart, and cancer services for skin cease to be available in a particular area. A commissioner would take on board that consideration. In my local area, a private dermatological bid has gone in regardless of what the hospital thinks, by virtue of the any willing provider rule currently applying.

Owen Smith: Does the hon. Gentleman accept that, although a commissioner may take that into account, it may be difficult for them to predict the incremental effect over time of cancer services for dermatological conditions being commissioned in a different way in a hospital? Does he also accept that the changes in tariff to which the Minister referred, which are ostensibly about trying to preclude some of this cherry-picking, increase the risk of it? Allowing commissioners to vary from tariff—allowing them to set separate prices and determine publicly why they have done so—is a charter for cherry-picking and for doing simple stuff more cheaply.

John Pugh: It is wholly unlikely that GPs or local nurses who are involved in commissioning would be unaware of the consequences for their local hospital. I spent last weekend talking to the leader of my pathfinder group at an open day at the local hospital. I would be very surprised if we found commissioners worthy of the name who did not understand the economy, the environment and the services provided by the local hospital. It is possible that a commissioner would not know the potential effects of his or her decision, but that person would be a very poor commissioner. Additionally, of course, the commissioner would have to have discarded duties that the legislation gives them, which the hon. Member for Leicester West did not mention—the duty to encourage integrated working and have regard to the impact on existing services in an area. The Government totally take the point that there could conceivably be a problem—that cherry-picking is bad—and we think that there is a solution on the table for it. The quality of that solution will be debated when we reach later clauses.

Margot James: I hope that Hansard will prove me right. The hon. Member for Southport said that I advocated the transfer of simpler services from hospitals to the private sector; I actually said that, where possible and applicable, such services might be transferred to the private sector and to local GP practices. There are countless examples of people who suffer from long-term medical conditions such as asthma and diabetes—some 17 million patients—who would profit from receiving the necessary attention for conditions from specialist GP practices that have developed expertise and employ specialist nurses. Such practices can provide those services closer to home, more cheaply and often to a better standard than a hospital service that is overrun.

The hon. Gentleman must remember that many of our hospital services are under considerable pressure. My hospital in Dudley is under huge pressure in a number of its specialties, and one reason for that is that too many people are attending as hospital out-patients when they could be treated in the community.

I refer to the example that was given in the choice and competition report from the recent listening exercise. The back and neck service in north-east Essex was under considerable pressure. The spinal unit at the hospital was under huge pressure, with the result that it could not deliver within the waiting times and it could not deliver an adequate service. The commissioners, who seemed an innovative bunch, resolved to cut waiting times, improve ease of access and reduce demand on the local spinal services by negotiating with GP practices and private providers in chiropractic, osteopathy and physiotherapy. The result of the exercise was that pressure on the spinal unit was reduced by 25%—a huge reduction. That will not close the spinal unit because it was under too much pressure before the commissioners got hold of the problem.

Children’s heart surgery is undergoing a significant reorganisation. My hon. Friend the Member for Winchester has a close interest in such matters, as I am sure do other members of the Committee. The other example to which I wish to refer is stroke services. There is a need for specialist consultants in several areas to undertake a critical mass of operations so that they can deliver the outcomes that are now expected. That cannot be done if they are constantly under siege by a system that promotes putting too many patients into hospital, when they can be better managed in the community.

I do not have the benefit of clinical experience, but I have certain knowledge of the issue, and that was the point that I was making earlier. I did not want it misrepresented by the hon. Member for Southport.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): I made a point about the impact on health and equality the first time that the Bill was debated in
Committee. It illustrated my concern that we still do not have the duty in respect of reducing health inequalities right.

The amendment would ensure that we assessed the impact of potential changes on providers. If changes threaten the viability of providers, that will automatically restrict access to care. Most providers in the private sector are trying to make a profit out of their contracts. They have strict clinical criteria, which will restrict patients with complex cases from accessing their services. Open cherry-picking arrangements will impact on health inequalities. We must be mindful that all that we do in respect of restricted access to care will not affect and worsen the position.

**Liz Kendall:** I am grateful to members of the Committee for their comments. When we discussed the Bill the first time in Committee, I might have said that its real difficulty was whether the whole series of changes to commissioning would drive the future shape of the NHS. We must bear in mind the almost parallel set of changes with Monitor, competition law and willing or qualified providers. I still believe that the Government have failed to explain how those two sets of changes connect.

The amendments would not prevent the shift of services out of hospitals into the community. The hon. Member for Stourbridge was right to say that that should done when it would improve care for patients and deliver better value for money, but such measures will have an impact on the financial and clinical viability of hospitals. The amendments would ensure that the national NHS board and local clinical commissioning groups would take that into account when making their decisions.

12.15 pm

**Question put,** That the amendment be made.

The Committee divided: Ayes 11, Noes 12.

**Division No. 9**

**AYES**

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. *(Easington)*
O’Donnell, Fiona

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

**NOES**

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

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

**Question accordingly negatived.**

**Mr Burns:** The amendments emphasise the importance of the duties of the commissioning board and clinical commissioning groups in relation to reducing inequalities and promoting patient choice and patient involvement. Those points will now be separated, so that the duties for patient involvement and patient choice will each be contained within their own, separate sections of the National Health Service Act 2006. The amendments also strengthen the duties for patient involvement and patient choice.

Proposed new section 13FA, inserted by amendment 70, and proposed new section 14NA, inserted by amendment 111, would oblige the commissioning board and clinical commissioning groups respectively, in exercising their functions, to promote the involvement of individual patients, their carers and any other representatives in decisions about the patient’s own care and treatment.

The duties are fundamental to our vision of a patient-centred NHS, where patients can expect “no decision about me without me”. The NHS Future Forum strongly argued that shared decision making between patients and clinicians needs to permeate the culture right across health care. The amendments prove that we are committed to shared decision making and the principle of “no decision about me without me”. The Future Forum said, however, that the commissioning board’s duty to “have regard to the need to” promote patient involvement, as it was originally worded, did not mirror the strength of our commitment, or sufficiently encapsulate the principle of shared decision making.

We have therefore placed the duties in separate sections to emphasise their importance and we have clarified the language, so that there can be no confusion about what is required from the commissioning board and the CCGs. The language of the sections now makes it clear that this is about involving patients in their individual care and treatment. Wider public involvement in service delivery is covered by separate duties created by proposed new sections 13L and 14P. If patient involvement is to be truly embedded, as the Future Forum recommended, it needs to be the norm for everyone—patients, clinicians, providers and commissioners.

We have also significantly strengthened the obligation on the board and the CCGs by removing their discretion on exercising that duty. The Bill establishes a duty on the board and clinical commissioning groups to have regard to the need to promote patient involvement when exercising their functions; the amendment will establish a direct duty on the board and the CCGs to promote patient involvement when exercising their functions. We have also added to the duties so that, where appropriate, the board and CCGs must promote the involvement of a patient’s representatives, as well as any carers, which better reflects the reality of patients’ relationships and the support that they might need to be actively involved in their care and treatment.

Amendment 111 will create a new power under proposed new section 14NA of the 2006 Act to provide specific guidance to clinical commissioning groups on fulfilling the patient involvement duty, and it specifies that CCGs must have regard to that guidance. The power provides a strong vehicle for the board to provide the clarity that the Future Forum and others have called for on the meaning of good patient involvement, what it involves and how it can become a reality for patients through
Mr Brine: I groaned because I am content that the Government are listening on these amendments. Given the amount that we have to get through, the Opposition should show some good grace and accept them with contentment too.

Liz Kendall: What the Opposition will do is say, “If only you’d listened to us last time round you wouldn’t have got yourselves into such a disastrous position.” This has been a wasted year both politically and, more importantly, for the NHS. We argued strongly last time in Committee that the requirements and duties on patient and public involvement were not strong enough. The Minister told us many times that we were wrong and that they were strong enough. He has now admitted that that is not the case and that is why he has had to change the legislation and table these amendments.

The Minister cites Rethink as being satisfied with all the Government’s proposed changes. Unless he popped out for a little break, he will have heard the comments from Paul Jenkins, the chief executive of Rethink and chair of the Richmond group of charities, and Jeremy Taylor, of National Voices. They said that they have not had sufficient time to consider not the Government’s response to Future Forum, but the amendments to the Bill. Jeremy Taylor said:

“We would not want this to be our last word, that’s for sure.” [Official Report, Health and Social Care Public Bill Committee, 28 June 2011; c. 63, Q139.]

We need to give patients and the public a stronger voice within the NHS. I still do not think that the Bill goes far enough. I welcome the comments that Paul Jenkins and other members of patient groups gave in evidence to us. They raised several points that are worth listening to. Simply putting this duty in as it is will not transform the NHS and give patients and the public a stronger voice.

There are three comments that we should consider in particular. First, there was a strong sense from Baroness Young of Diabetes UK and the witness from the Stroke Association that these amendments, which are about giving individual patients a say on their treatment, are not strong enough on the collective public voice about the future shape of our health services. That is critical.

We will face difficult decisions about the future of local hospital services. We need to involve people not only as individual patients who use those services, but as a community as a whole. There will be some very difficult decisions, trade-offs and checks and balances. I do think that the Government have a plan for how they will deal with this. I raised this last week. In six months’ time, hospitals will face a massive financial crunch. Very difficult decisions will have to be taken. Having a much stronger and clearer sense of how we as citizens and members of the public are involved in decisions is vital. I do not think the Bill is strong enough in that regard.

The second issue is this. As Jeremy Taylor said:

“The duty of public involvement still reads very much along the lines of the old section 242 template of informing and consulting. That is still the model of public involvement that is expressed in the Bill as amended. Many of us here think that that is a rather old-fashioned way of engaging and involving people, and we would like to see something a bit stronger.” [Official Report, Health and Social Care Public Bill Committee, 28 June 2011; c. 65, Q141.]
It is not a case of telling people what we want to do and then asking for their views about it. We need something fundamentally different. The Health Foundation submitted evidence to the Committee via e-mail yesterday. It said that if we really believe in both the individual involvement of patients in all the decisions about their treatment in care and the need to involve the public, as citizens, in difficult decisions about the future shape of hospital services, we need to define that and set it out clearly in the Bill. Unless we do that, the NHS will not be able to make the £20 billion of efficiency savings or improve patient care. The duty is not going to transform the way in which we do public involvement and consultation.

My final point on the patient choice and involvement duty relates to an issue that has been raised by both the Royal College of Paediatrics and Child Health and the National Children’s Bureau. They also submitted evidence yesterday and are concerned—this was mentioned in the Future Forum report, but not in any of the Government’s responses—that the views and voices of children and young people are not being heard. The NHS has been poor at making sure that children and young people have their say. It is disappointing that that has not been recognised. It was mentioned in the Future Forum report, but the Government’s response has not focused on it. Those organisations took the time to give evidence to the Committee at short notice, so it is only right that we should raise that issue.

Fiona O’Donnell: I want to speak briefly—I hope the Committee will indulge me—about the Scottish experience of consultation and involving patients. Two terms ago in the Scottish Parliament, the Kerr review looked, in part, at A and E services in Scotland. It was decided that certain local A and E services should be closed, with a view to offering people, in the event of a heart attack or a stroke, better outcomes by making them travel slightly further for a more specialist service. That was the conclusion of the Kerr report, and it was also the view of the clinicians involved in providing services locally. The community objected, as was its right, and that happened to coincide with an election. A decision was then made—we have to be watchful of whether this is populism or genuine community engagement and involvement—and services were retained. Subsequently, the clinicians changed their minds and decided that that was better. We have to be clear about the processes and enable those people whom we are trusting and empowering to make decisions to get on with doing that effectively.

I am sure that every member of the Committee has received submissions on involving young people, especially those with multiple and complex needs as a result of physical and learning disabilities. The Future Forum was clear that those young people must have a voice, and it seeks clarification from the Minister about where their voices will be heard, not just as children, but as they make the transition from using children’s services to using adult services. It is often the case that there is nothing appropriate in the area and that only paediatric or geriatric services are available. When we talk about choice, it will be outwith the area, because specialist service provision for children or young adults with complex needs may not be available in the area where they live.

Finally, the Minister mentioned direct payments, which have been welcomed broadly. We also have them in Scotland, so I have knowledge of them. However, only yesterday, and as we have discussed, the Dilnot report raised concerns about quality. Where is the quality guarantee to ensure that, when we give patients power, the services that they access, especially for vulnerable adults and children, are of a quality that safeguards their interests?

Graham M. Morris (Easington) (Lab): I want to make a brief point and to invite the Minister to clarify a particular issue. I had hoped to make an intervention, but I could not catch his eye. My point relates to a statement that the Secretary of State made to the House on 14 June about the NHS Future Forum after it published its report. He made a point about co-operation and competition, in which he said that it was the Government’s intention to place the “Principles and rules for cooperation and competition” on a statutory footing. I presume that those are the elements that we are dealing with now. [Interruption.] Did the Minister want to intervene? It would be useful to have some clarification—

Mr Burns: This is not relevant.

Graham M. Morris: If the Minister will bear with me, it will perhaps be a little clearer.

The issue relates to the role of any qualified provider in the choice agenda and in patient choice. Given that on 14 June, the Secretary of State said:

“We will keep the existing competition rules introduced by the last Government—[Official Report, 14 June 2011; Vol. 529, c. 646.]”—the March 2010 rules, which included the preferred provider—is the amendment an attempt to clarify that and move the Secretary of State’s position, as stated on 14 June?

Debbie Abrahams: I want to support my hon. Friend’s remarks. The amendment does not strengthen the importance of public and patient involvement, and public involvement in particular is so important.

I want to comment on proposed new section 13F(1) to the 2006 Act. A recent survey—I will have to dig it out for the Minister—stated that what patients and the public want is a good local provider. I am concerned that the proposal is more about promoting competition than promoting patient choice in care pathways. I want a response from the Minister on that.

Mr Burns: I will be brief, because I am sure that the Committee wants to make progress. There is a considerable amount of work left to do.

It has been an interesting debate. I am glad that, on balance, we have the support of the hon. Member for Leicester West on the strengthening of the Bill and the improvements that we are making to it, because patient involvement is critical to a modernised NHS. I am glad that she welcomed the fact that we have listened, strengthened and improved. That has certainly been the view of several outside bodies that I have cited, although I will deal with the hon. Lady’s point about Rethink.

The hon. Members for Leicester West and for East Lothian—and, up to a point, the hon. Member for Oldham East and Saddleworth—have raised an important
[Mr Simon Burns] issue about involvement and taking the views of young people and children. That is valid. We have been working closely with Paul Jenkins, the Richmond Group of leading charities and others, and we will continue to do so. Although we paused, and the pause is over, we will never stop listening. We will continue to listen and to consult; that is an ongoing process.

Amendment 111 gives powers to the commissioning board to publish guidance for CCGs on patient involvement, and we will obviously expect a close working relationship with patient groups. As highlighted by the hon. Ladies, in this crucial area it is important to ensure that we do not miss out on consulting and getting involvement from young people and children, individually and through their organisations, so that they are not forgotten in the general consultation process on formulating the guidance. I hope that is helpful.

It is also important to say that the amendments deal with patient involvement, and public involvement is different. Some of the speeches I listened to mentioned public involvement, and there were valid points and some criticisms, but they must be put in context. The amendments deal with patient involvement and we will come to public involvement in clause 22.

We are delighted to see the hon. Member for Easington taking his place in the Committee this morning, but I think it fair to say, in kindness, that the trouble is that he arrived a little too late; his comments addressed the previous debate, not this one. If he reads Hansard tomorrow, he will know what we said about any qualified provider.

The amendments significantly strengthen the Bill. They are important for the advancement of patient involvement and choice, and patient presence at the heart of the NHS. I urge my hon. Friends to support the amendments if the Opposition, surprisingly, decide to oppose them.

Amendment 68 agreed to.

Amendments made: 69, in clause 19, page 17, leave out lines 11 to 14.

Amendment 70, in clause 19, page 17, line 16, at end insert—

13FA Duty to promote involvement of each patient

(1) The Board must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions about the provision of health services to the patients.

(2) In this section, “health services” has the same meaning as in section 13F.

13FB Duty to patient choice

(1) The Board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

(2) In this section, “health services” has the same meaning as in section 13F.”—[Mr Simon Burns.]

Mr Burns: I beg to move amendment 71, in clause 19, page 17, line 18, leave out from ‘must’ to ‘advice’ in line 19 and insert ‘obtain’.

The Chair: With this it will be convenient to discuss Government amendments 72, 112 to 114 and 135.

Mr Burns: I shall be brief because the Committee wants to make progress.

The amendments strengthen the duty on the NHS commissioning board and CCGs to obtain appropriate clinical advice. Clinically-led commissioning is at the heart of our vision for the NHS. We want decisions about local services to be taken by those who are best placed to work with patients and the public to understand their needs. The NHS Future Forum endorsed that vision, but it was correct to say that the Bill did not fully reflect that ambition.

In particular, we recognise that everyone who has a role to play in developing better services for patients should be able to do so. There are non-legislative ways in which we propose to strengthen the opportunities for that, such as extending clinical networks—bringing together experts to provide advice on distinct areas of care, such as cancer or maternity services—and establishing clinical senates, which will bring together a range of multi-professional experts across particular parts of the country to provide cross-cutting advice on strategic commissioning decisions.

The proposals prompted a lot of debate in our last session, so let me make a few points clear. Networks and senates will not be new organisations or new forms of bureaucracy. Their purpose is to embed clinical expertise at the heart of the board and to provide both clinical commissioning groups and the board itself with access to a broad range of expert clinical input, to support and inform commissioning decisions.

Cancer Research has welcomed our commitment to establishing clinical networks and senates, noting that “involving a range of experts in cancer commissioning and ensuring different parts of the service are joined up is crucial to delivering high quality treatment for a complex set of conditions like cancer.”

The Royal College of Physicians and Bliss, the special care baby charity, have also welcomed our commitment to strengthen critical networks and give them a role in advising commissioners. In addition, the NHS Confederation has said that setting up clinical advisory bodies to support consortia could be a positive way forward. However, the Future Forum also recommended that we strengthen the legislative duties on NHS commissioners to seek a wider range of advice in performing their functions. That was something that the BMA also called for, and the amendments do exactly that.

12.45 pm

Amendments 71 and 112 change the wording of the duties of the commissioning board and the clinical commissioning groups, under proposed new sections 13G and 14O respectively, to “obtain” appropriate advice. Rather than being required to make arrangements with a view to obtaining advice, the board and the CCGs will be directly required to obtain advice, which is a much clearer and stronger duty.

Amendments 72 and 113 place a more direct duty on the board and the CCGs to obtain advice appropriate for enabling them to discharge effectively their functions from a broad range of professionals with expertise in the prevention, diagnosis or treatment of illnesses, and in the protection or improvement of public health. That applies to the exercise of all their functions—including, for example, obtaining advice when making commissioning decisions and when the commissioning board designs NHS pricing structures.
The key to improving patient care and delivering better value for money for taxpayers is absolutely about what happens in those community health services. It is about how those services help patients stay fit and healthy and live independently, so that they do not end up having to go to their GP or into hospital and A and E. Those patients are not mentioned in the Government’s response to the Future Forum or in the amendments. That is a significant gap and a big mistake because it means that the Government will not be able to get the NHS to achieve what they want it to. I urge them to look again at that.

The third issue is also critical. We have absolutely no idea how any of this stuff will be funded. How will the clinicians advising the consortia or commissioning groups, working on the clinical senates or working in the clinical networks be funded? Even if their roles are unpaid in that respect, what degree of senior locum cover will we get?

There is talk of there being 30 clinical senates across the country—goodness knows how many clinical commissioning groups there will be. How will the Government fund them? What calculation has the Minister done on that? Will that be in the health impact assessment? A large expense will be created. When the NHS is under huge pressure, it is only right that the Government spell out the costs of their plan as they have claimed that they will save a huge amount of money. The sums do not stack up.

Fourthly, I would like the Minister to tell the Committee what the status of the advice provided by these different groups is. What if the people giving the advice to the board or the consortia give advice different from that of the clinical senates or the clinical networks? Who has the final say? Will they be the same people or will they be different? As my hon. Friend the Member for Sedgefield said, it is a dog’s dinner. I could not have put it better myself. As always, I am looking forward to the Minister’s answers to all four of those questions.

Mr Burns: The hon. Lady started so well. As I think you said during our previous debate, Dr McCrea, one got the impression that there was unanimity on the Committee. I thought that, too. However, we were misled because the hon. Lady then went into attack mode and seemed to nit-pick her way through—

Liz Kendall: It is scrutiny.

Mr Burns: I understand that it is scrutiny, but there is a difference between scrutiny and nit-picking, and sometimes the hon. Lady tends to veer towards the nit-picking end of the spectrum. Most of the time, she scrutinises quite well and responsibly. Now I shall give her some answers.

The hon. Lady seems to think that the clinical senates are organisations—or that is what she calls them. I have told her that they are not organisations, simply because they are not.

Grahame M. Morris: Will the Minister give way?

Mr Burns: Let me explain first, because the hon. Gentleman has come late to today’s proceedings and is playing catch-up. Despite what the hon. Member for Leicester West, her right hon. Friend the Member
for Rother Valley and her hon. Friend the Member for Easington like to say, this is not creating additional bureaucracy. The changes that we are making to the Bill do not create any extra statutory organisations. Clinical senates and networks, as I said during the previous debate, are not new organisations in their own right. They will be hosted by the NHS commissioning board, minimising bureaucracy while maximising benefits for patients.

Grahame M. Morris: The Minister says that these are not new organisations. I fully understand that the cancer care networks and some of the cardiology networks are already established. However, my understanding of an article by Sir David Nicholson in the *Health Service Journal* last week is that the intention is to create between 14 and 17 of what he refers to as “health systems”, which will comprise senates. Does the Minister agree with the chief executive’s assessment of the numbers, or does he have a different view?

Mr Burns: I think it is, by definition, what the hon. Gentleman has just read out. That was the range that the chief executive gave of how many there may be.

Grahame M. Morris: Most of them are new.

Mr Burns: I was just getting on to that. The hon. Member for Leicester West keeps asking—this might help the hon. Member for Easington as well—what clinical senates would do. They will provide advice and support on a range of issues, providing a more robust and reliable system to assist commissioners in fulfilling their statutory responsibilities in ways that draw on and take account of the very best clinical leadership, advice and support. They will work with the board in their support of clinical commissioning groups, advising on whether commissioning plans are clinically robust and on the clinical implications of major service changes.

The hon. Member for Leicester West also asked whether this is just more bureaucracy.

Liz Kendall: I did not use that phrase.

Mr Burns: No, but the implication was there.

Liz Kendall: I was careful with my words.

Mr Burns: Okay. The hon. Lady did not ask that question, so I can save the Committee’s time by not answering it.

The hon. Lady also asked who will have a say and what legal force the senates will have. As Dr Kathy McLean said in her evidence, commissioners hold the statutory functions, so they have the final accountability for decisions. Senates and networks are there to advise them. They do not have statutory responsibilities—they are advisory bodies.

With that, I will conclude so that we can finish debating the amendment before the break. I urge my hon. Friends to support the amendments, which the hon. Lady started to support until her rhetoric veered her away from them.

Liz Kendall: The Minister has not answered my question about what the difference is between a senate, a network and the people who will give advice to the clinical commissioning groups. He has not answered the question about their costs, how they will be funded or the local cover. He has not answered my point that there is no mention of community health services.

I am always careful with my words. I ask questions that are designed to get to the facts, and I hope that the Minister will now respond to those three questions.

Mr Burns: On funding, we come back to the same old question—the hon. Lady will have to be patient and wait for the new impact assessment. She knows when it will be published, so I do not have to repeat that. On community health services, the exact point of senates, as I have already said, is to bring together professionals from different parts of the system to discuss how to provide joined-up services for patients. Those working in the community could play a key role in senates, and we hope that they will.

Amendment 71 agreed to.

Amendment made: 72, in clause 19, page 17, line 20, leave out from ‘persons’ to end of line 21 and insert ‘who (taken together) have a broad range of professional expertise in—

(a) the prevention, diagnosis or treatment of illness, and

(b) the protection or improvement of public health.’—

(Mr Simon Burns.)