Public Bill Committee

HEALTH AND SOCIAL CARE
(RE-COMMITTED) BILL

Sixth Sitting
Tuesday 5 July 2011
(Afternoon)

CONTENTS
Clauses 19 to 21, as amended, agreed to.
Schedule 2, as amended, agreed to.
Clauses 22 to 24, 28 and 29 agreed to, some with amendments.
Schedule 3, as amended, agreed to.
Adjourned till Thursday 7 July at Nine o’clock.

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Saturday 9 July 2011

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

*Chairs: † 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
Public Bill Committee

Tuesday 5 July 2011

(Afternoon)

[Dr William McCrea in the Chair]

Health and Social Care
(Re-committed) Bill

Clause 19

THE NHS COMMISSIONING BOARD: FURTHER PROVISION

4 pm

The Minister of State, Department of Health (Mr Simon Burns): I beg to move amendment 73, in clause 19, page 17, leave out lines 40 to 44 and insert—

13J Duty as to promoting integration

( ) The Board must exercise its functions with a view to securing that the provision of health services are provided in an integrated way where it considers that this would—

(a) improve the quality of those services (including the outcomes that are achieved from their provision),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

( ) The Board must exercise its functions with a view to securing that the provision of health-related services or social care services where it considers that this would—

(a) improve the quality of the health services (including the outcomes that are achieved from the provision of those services),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

The Chair: With this it will be convenient to discuss Government amendments 74 and 117.

Mr Burns: I am aware, Dr McCrea, that we have considerable work to progress through in the next four hours, so I shall be as swift as I can.

One of the main themes in the NHS Future Forum report was the need for better collaboration and integration between different care sectors and settings. Although it is acknowledged that there are many examples of integration between health and social care, too often services have been fragmented and have failed to join up for the people who use them. The amendments strengthen and expand the provision in the Bill for clinical commissioning groups, and replace the board’s current duty in relation to integration.

Having listened to the concerns of the Future Forum and others that the existing duties on the board and CCGs are insufficient to promote integrated care centred on the needs of patients, we are responding with these amendments, which reaffirm the Government’s commitment to integration. National Voices said in response to the Government’s announcements on 14 June:

“The Government has listened to patients and charities. National Voices called above all for ‘integration, integration, integration’, meaning that patients should get seamless services and continuous care. The government has highlighted that goal and given duties to secure it.”

The King’s Fund has said:

“the new emphasis on integration…offers the most promising approach to addressing demographic change and supporting the increasing number of people with long-term conditions.”

The amendments have also been welcomed by the Royal College of Physicians, the NHS Confederation, the Academy of Medical Royal Colleges and the Nuffield Trust.

By inserting new section 13J into the National Health Service Act 2006, the Bill places a duty on the board to exercise its functions with a view to encouraging CCGs to work closely with local authorities in arranging for the provision of services. We recognise that that could be perceived as giving the impression that partnership working is an end in itself, and I therefore seek to amend new section 13J with amendments 73 and 74, which place a duty on the board to promote integration by requiring it to exercise its functions with a view to securing that health services are provided in an integrated way when it considers that that would be beneficial to the people receiving those services.

The new duty is concerned not just with integration between health services or health and social care services, but with the integration of health and health-related services such as housing that might have an effect on the health of individuals but are not health or social care services. An equivalent new duty is being placed on CCGs, and I will come to the relevant amendment in a moment. The amended duty requires the board to exercise its functions with a view to securing that health services, health and social care services, and health and other health-related services are provided in an integrated way if it considers that that would either improve the quality of health services and their outcomes, or reduce inequalities in access to and outcomes from health services.

Integration can be an effective means of tackling health inequalities. People in disadvantaged groups, for example, often experience multiple disadvantages and complex co-morbidities. The new duties to promote integration would cover integration between service types, for example between health and social care, and between different types of health services. Whatever the combination and however the services are integrated, the practical effect should be that services are co-ordinated around the needs of the individual. The duty would apply to the board in the exercise of all its functions, not just its commissioning ones.

The board will be able to promote innovative ways of demonstrating how health services can be provided in a more integrated way, for example by developing tariff currencies for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care, in line with the Government’s wider proposals on community budgets. Amendment 117 puts the same duty to promote integration on CCGs. Clause 192 already requires CCGs, as members of health and well-being boards, to encourage integrated working between
commissioners of NHS, public health and social care services for the benefit of the health and well-being of the local population. Amendment 117 builds on that requirement and takes it significantly further. CCGs could comply with the duty, for example, by choosing to commission services jointly with local authorities. To my knowledge, this is the first time that a Government have proposed in primary legislation a duty requiring NHS commissioning bodies to promote integration, and it demonstrates our strong commitment to integrated services centred on the needs of patients.

Mr Kevin Barron (Rother Valley) (Lab): It is a pleasure to see you in the Chair today, Dr McCrea. Listening to a debate about a Government amending a Bill that only a few short weeks ago they were defending was a first for me. This morning was the first time in 28 years I have had that pleasure.

The Future Forum rightly pointed out the difficulties with integration in health care, including the difficulties in the national health service now. In its paper, “Choice and Competition Delivering Real Choice”, it stated: “It is clear the health service now needs to drive integration in a way that has simply never happened to date. In practice, current contracting processes, funding streams and financial pressures can actually discourage integration.”

That is true in my experience of health care. It goes on: “There needs to be a culture in the service that both encourages innovation and supports collaboration…But there are still too few examples where NHS organisations have worked with each other to provide that integrated care. If commissioners want to commission integrated care they will only succeed in doing this by creating a new market in integrated care services and stopping the current commissioning of episodic services from different NHS organisations.”

We are celebrating the 63rd birthday of the NHS today—I had my piece of cake on the way in. That those words ring true is a bit of a condemnation of our health care system, particularly when we realise that 70% of the expense of the NHS goes on looking after people who have long-term conditions—not only one condition, but two and sometimes many more. We still have a disconnect, particularly between primary and secondary care, so I hope the intention behind the three amendments is to bring that under statute and ensure that the position changes.

I have a question about what the Minister has just said. Members know that on two occasions during the previous Committee sitting, I brought up primary health care services that are not connected, such as dentistry, pharmacy and optometry. The NHS commissioning board has a responsibility to negotiate the national contract, but there is no statutory responsibility to talk to those three services’ organisations. The original new section 13J in clause 19 said that the board must “exercise its functions with a view to encouraging commissioning consortia to work closely with local authorities in arranging for the provision of services.”

I genuinely thought that the intention behind amendments 74 and 117 was to bring in those wider health care services, as we call them, although they are provided by the independent sector.

Amendment 74 says “‘health-related services’ means services that may have an effect on the health of individuals but are not health services or social care services”.

I thought the Minister would mention other primary care services provided in the community by other health care professionals, but the only example he used was housing. Housing is normally, although not in all cases, a local authority function—there is social housing and some privately owned housing. Are we talking about the wider health community that is providing services to NHS patients now through primary care extended services, such as smoking cessation and weight loss clinics?

Mr Burns: If it helps the right hon. Gentleman, the answer to his question is yes.

Mr Barron: I am very pleased about that and I suspect that pharmacists, dentists and optometrists outside will be happy to hear it as well, because the original Bill caused great concern. I declare an interest as chair of the all-party group on pharmacy. I have an avid interest in public health and what pharmacists are doing up and down England to help people with lifestyle issues and wider problems, such as long-term conditions. I am pleased that the Minister has made that intervention, but a concern from the original Bill still stands.

The national commissioning board will issue quality standards to commissioners and providers about providing the right type of service. Does the Minister believe that that mechanism, under the newly amended clause 19, will be used to ensure that integration in commissioning takes place properly? The Future Forum and many others believe that that has not been very good in the past, as I have mentioned. I would genuinely like to hear him say that the problem will be addressed, and one way or another, I hope that we will see proper integration of services through the amendment. I would like the Minister to say that it will be about the wider national health service family and not only statutory public bodies, such as local authorities and NHS bodies. If we are going to take a comprehensive view on improving health care and the population’s health, it is integral to local commissioning that the health of the public is high on the agenda.

Liz Kendall (Leicester West) (Lab): As my right hon. Friend has said, there are some small “Happy Birthday NHS” cakes outside that have been donated by the TUC. Opposition Members will eat them with relish, and I am sure that they will be offered to those on the Government Benches, too, with the proviso that the NHS sees its birthday next year.

I want to say a few words about the duty to promote integration, and I shall repeat a point, as I have done many times today. We argued strongly during the first proceedings that the Government’s original Bill risked setting different parts of the NHS against one another, even though integrating health services both within the NHS and within social care is absolutely vital to improving care for our ageing population and for people with long-term and chronic conditions.

I want to correct the Minister, because he listed a number of organisations that he said welcomed the amendments. I do not think that they did, however. They may have welcomed what the Government said they would do in response to the Future Forum document, but those organisations had not had a chance to read the amendments, and it is important that the Minister is accurate in that regard.
Mr Burns: For further accuracy, let me correct the hon. Lady. The words I used were, “In response to the Government’s announcements on 14 June”.

Liz Kendall: Perhaps the delicious cake temporarily affected my hearing. I was pretty sure that the Minister said “amendment”. We shall see from the wonderful Hansard what is actually correct.

I am still concerned about the duties to promote integration as they are set out in the Government’s amendments. The proposals remain weak. It is unclear why the duties to promote integration relate only to quality and inequalities in access and outcomes. Why not consider promoting integration where we think it might help to deliver more efficient services that would secure better value for money, particularly considering the financial situation of the NHS?

The importance that the Government have put on promoting integration is also interesting, when we look at what appears to have been a leaked document about the design of the NHS commissioning board, which has been made public today. This relates to a point from this morning. As hon. Members will recall, the Minister clearly said that he was unable to answer my question about how much money would be spent on the new NHS commissioning board. He was unable to answer my question about how many staff would be employed, and precisely what all its functions would be. He said that it was too premature in the process. Yet the document, “Designing the NHS Commissioning Board”, which was leaked today, and is described as “revised version 3—post listening”, lists clearly a range of functions and responsibilities that the commissioning board will take on.

There are two possible reasons why the Minister was unable to answer my questions today. Many are answered in the document, which is post the listening exercise, so not that long ago. Either the Minister did not know that it had been written and he has not read it, or he was aware of it but was not prepared to tell MPs.

Mr Burns: Will the hon. Lady give way?

Liz Kendall: Perhaps the Minister will let me finish. First, on the specific clause, there is very little so far about promoting integration. If there is such a strong duty on the commissioning board to promote integration, I have yet to find a requirement for that. Secondly, the document clearly states: that the new commissioning board will employ 3,500 staff. If David Nicholson, the chief executive designate of the NHS commissioning board, knows how many staff he will employ, he will have a good idea how much they will be paid, as well as understanding the board’s different functions.

The document gives a detailed explanation of what the board will do and what its functions will be. It will work on five domains—for example, it will have a finance director—and all are listed in the document. If the assessment is so clear, why could the Minister not answer our questions about what the board will cost and how many staff it will employ? Does he know what is going on in his own Department, or is he simply not prepared to tell MPs, whose job here today is to scrutinise the Government’s huge reorganisation of the NHS?

Fiona O’Donnell (East Lothian) (Lab): Perhaps it is my naivety, but I am disappointed that the document has not been made public before, given that it would at least have provided the opportunity for organisations and members of the Committee more effectively to scrutinise the Bill. My hon. Friend has referred to 3,000 or 3,500 staff, but the Minister has referred to an initial phase of a year when it appears that not much will happen. How many people will be employed during that period?

Liz Kendall: With the greatest respect to my hon. Friend, I do not want to reply on behalf of the Government about their plans. What I can say is that according to the document, the board “will need to perform a very significant and varied set of tasks to support improvements in outcomes.”

The Minister told us earlier that the cost of the new board will be limited, but that does not fit with a board that has “a very significant and varied set of tasks.”

Those tasks include:

“Finance, Performance and Operations…Commissioning Development…Patient and public engagement, insight and informatics…Strategy and transformation…Policy and corporate development”.

There is also a chief of staff. All those functions will have separate directorates within the board.

Owen Smith (Pontypridd) (Lab): Further to the question asked by my hon. Friend the Member for East Lothian, does the document not also say that 3,500 staff will be employed during the year October 2012 to October 2013, when the board will be in shadow form? The document states clearly that all staff will be employed and all roles will be filled in that year, prompting the question how much will that cost?

Liz Kendall: My hon. Friend is right. The board will be ready in shadow form, as the Minister has said, from October this year. It beggars belief that the Government do not know how much that will cost, who the staff will be, what their salaries will be and what other functions and support will be required. The document contains all sorts of information about how the board will work locally, but the Minister has so far refused to say whether it will have regional outposts, although we have asked constantly. Now we hear that about two thirds of staff will work out and about in the local area, supporting professional and clinical leadership functions, direct commissioning functions, relationships with clinical commissioning groups and stakeholder relationships.

Mr Barron: When the old Committee took evidence from Sir David Nicholson, it was hinted that there might be people on the ground, but the leaked letter says on page 5 that the national commissioning board will “commission directly around £20 billion of services including specialised commissioning and local primary care services (including holding around 33,000 contracts for primary care services)”.

The policing of that will mean lots of people from the national commissioning board in our local neighbourhoods.

Liz Kendall: My right hon. Friend is correct. It would appear—
Grahame M. Morris: On a point of order, Dr McCrea. Is it in order for the Government to have information and withhold it from the Committee?

The Chair: What the Government have is not a matter for the Chair. I have given the hon. Lady a bit of leeway to deal with this matter, so I will allow her to continue.

Liz Kendall: I am grateful to you, Chair, for allowing us to raise the issue. It is important in light of the Minister’s refusal to answer questions this morning that his own Department has clearly got far along the line in thinking through. In conclusion, the draft gives us a much clearer idea of the timetable for setting up the board. Again, we received very little information on that from the Minister. The draft states:

“Summer 2011: Further detail published about the operating model of the Board including its key processes. Arrangements for senior appointments published.”

It is fairly hot at the moment; I imagine that this is the summer, even if it is a British summer. We are in the summer now. Why do we not know the senior appointments and how much those people will be paid?

“Autumn 2011: Further publication setting out proposed structure for the Board…October 2011: Potential start date”.

I feel that we have not had as much information as I would expect from the Minister about the number of staff and the potential costs of the board. If the Department does not know what it will cost, although I am sure that it does—

Owen Smith: Is there not another important point here? If the board is to recruit 3,500 people during 2012-13, the year of its shadow inception, presumably those 3,500 people will be recruited from the strategic health authorities and primary care trusts that still exist at that point. Will that not cause chaos?

Liz Kendall: One reason why I am sure the Prime Minister was unable to answer the question put to him by the Leader of the Opposition last week about whether he could guarantee, after £850 million had already been spent on redundancy payments, that the people made redundant would not be re-employed in the system, is that there are clearly plans to do so. On that point, understanding that we have stretched the focus of this debate—although rightly, in pursuit of effective scrutiny—I finish my comments.

Mr Burns: I am glad that the hon. Lady, in her charming and incisive way, has had a little bit of fun, but I say to her that no document has been published and that we do not comment on leaks. As I said to her this morning when we discussed the future of the commissioning board, she has been a little unfair to me, because she referred to something in the document that apparently involved seeking employment for certain people on the commissioning board. If she was listening to me last Thursday, she will remember that when she asked what was happening, I said that there had been an advertisement and that there would be further advertisements shortly.

Mr Burns: Let me finish this important point.

This morning, the hon. Lady asked about the timetable for the progress of the commissioning board as a shadow authority and when it will start operating in full. I gave her the dates, because there seemed to be a little confusion on the hon. Lady’s part as to which years it would be. I am sure that she remembers that. The bottom line is that she may have a leaked document. However, the document has not been published, and I do not wish to comment on leaked documents at this point. I shall stick by what I said this morning.

On costs and so on, the full details will be made public in due course, but they will also be included in the impact assessment. As I said this morning, if the House is willing, that will be produced when the Bill passes from this place to the other place.

Grahame M. Morris: This really important point runs to the heart of the business that we are about, which is effectively scrutinising the re-committed Bill. The chief executive of the national health service, Sir David Nicholson, was prepared to comment on the matter this morning to the Health Select Committee. It is incredible that information that is freely given to the Select Committee should be withheld from us.

Mr Burns: The hon. Gentleman has made frequent contributions to our debates, much to our merriment at times. I congratulate him on that try, but I repeat that no document has been published, and I am not going to comment on leaked documents.

Debbie Abrahams: This really important point runs to the heart of the business that we are about, which is effectively scrutinising the re-committed Bill. The chief executive of the national health service, Sir David Nicholson, was prepared to comment on the matter this morning to the Health Select Committee. It is incredible that information that is freely given to the Select Committee should be withheld from us.

Mr Burns: I hope that understood the context of the hon. Lady’s intervention, and that she was not suggesting that I am not trustworthy. I think that she was not doing so—[Interruption.] That would take things to another level. The Committee has been conducted on trust. I repeat what I said earlier. No document has been published. I do not believe that the document alluded to by the hon. Member for Easington was provided to the Health Select Committee this morning. I am not going to indulge in conversations about a leaked document that I do not have before me.

Owen Smith: Although we are not suggesting that the Minister is in any way untrustworthy, the point raised by my hon. Friend the Member for Oldham East and Saddleworth was very well made. The document was provided by the Clerk to the Health Committee this morning. It was on the Health Service Journal website earlier this week. It was leaked, and it is therefore in the public domain. The chief executive designate of the NCB saw fit to comment on it. Ministers cannot hide behind the fact that is a so-called leaked document. Others have already commented on it, and people will not trust the Minister and others if they are not prepared to comment on it.
Mr Burns: The hon. Gentleman is a distinguished lawyer, I believe.

Owen Smith: That is news to me.

Mr Burns: Is he not? I understood that he was a lawyer and had legal training. If not, I am insulting him. I thought that he was a lawyer and I apologise profusely. However, he speaks like one, because he is playing with words. As I understand it, the document that he is talking about has not been published. It is a leak to the Health Service Journal that was put on a website, printed off the website and given to members of the Health Committee. I may have misunderstood the situation, but that is my understanding. The document has not been published and, for that reason, I am not going down the route of commenting on leaks. The hon. Lady can have one more try and then I will not take any more interventions.

4.30 pm

Liz Kendall: Will the Minister comment on the proposal that the board should be called NHS England? A little note has been put in the document that says, “Is this going too far?” Does he agree that it should be called NHS England?

Mr Burns: The hon. Lady is trying to tempt me by going round in circles. I will spell it out once more in plain English, so that she understands. No document has been published.

Grahame M. Morris rose—

Mr Burns: Just sit down, please. No document has been published and I am not going to stand here discussing leaked documents. I did say to the hon. Lady that I will not be giving way anymore. Given that the Chair has generously given a lot of leeway during the debate, I want to bring the discussion back to the substance of the amendment. I think that the right hon. Member for Rother Valley would like an answer to his points about quality standards and integration. I say to him that the integration duty applies to all the board’s functions, including the publication of commissioning guidance, which will be based on National Institute for Health and Clinical Excellence quality standards. I hope that he finds that helpful.

I also want to refer to another point that the right hon. Gentleman made. I reassure him that the board will be able to promote innovative ways of demonstrating how health services can be provided in a more integrated way. As I said in my original comments, that includes, for example, developing tariff currencies for integrated pathways of care and exploring opportunities to move towards single budgets for health and social care in line with the Government’s wider proposals on community budgets. I hope that he finds that of assistance. For those reasons, not withstanding the distraction of an apparent leaked document, I urge my hon. Friends to support the amendments, because they are an important way forward for integration.

Amendment 73 agreed to.

Amendment made: 73, in clause 19, page 18, line 3, at end insert—

(1) In this section—

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

“health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;

“social care services” means services that are provided in pursuance of the social care services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).’.

(Mr Simon Burns.)

Mr Burns: I beg to move amendment 75, in clause 19, page 18, line 14, at end insert—

“13KA Duty as respects variation in provision of health services

The Board must not exercise its functions for the purpose of causing a variation in the proportion of services provided as part of the health service that is provided by persons of a particular description if that description is by reference to—

(a) whether the persons in question are in the public or (as the case may be) private sector; or

(b) some other aspect of their status.’.

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

Government amendments 153, 160 and 171.

Government new clause 4—Secretary of State’s duty as respects variation in provision of health services—

‘After section 12D of the National Health Service Act 2006 insert—

“Miscellaneous

12E Secretary of State’s duty as respects variation in provision of health services

(1) The Secretary of State must not exercise the functions mentioned in subsection (2) for the purpose of causing a variation in the proportion of services provided as part of the health service that is provided by persons of a particular description if that description is by reference to—

(a) whether the persons in question are in the public or (as the case may be) private sector; or

(b) some other aspect of their status.

(2) The functions mentioned in this subsection are the functions of the Secretary of State under—

(a) sections 6E and 13A, and

(b) section 67 of the Health and Social Care Act 2011 (requirements as to procurement, patient choice and competition).’.”

Mr Burns: This is an important group of amendments, because the Government have made their commitment not to privatise the national health service absolutely clear. We will safeguard the principle of NHS services being for all those who need them when they need them. That has been and remains our unequivocal position.

However, as the NHS Future Forum highlighted, there were concerns that the Bill, as drafted, could lead to some people maintaining that there would be a possible privatisation of NHS services or some sort of dogmatic preference for the private sector. The report recommended that...
"the Government should not seek to increase the role of the private sector as an end in itself. Additional safeguards should be brought forward."

In responding to the report, the Government made clear their intention to outlaw any policy to increase the market share of any particular sector or provider. What matters is the quality of care that a provider offers—free at the point of use to NHS patients—not its ownership model or status.

These amendments put our position beyond doubt. They would prohibit any policy designed with the purpose of varying the market share of any particular sector or provider.

Owen Smith: Will the Minister give way?

Mr Burns: No, not for the moment. The amendments would prevent the commissioning board, Monitor, and in certain circumstances the Secretary of State, from having a deliberate policy aimed at encouraging the growth of the private sector over existing state providers, or vice versa. That would apply to Monitor and the NHS commissioning board in everything they do across all their functions. It would apply to the Secretary of State when setting objectives and requirements for the NHS, whether through the mandate and standing rules for commissioners introduced by clause 16, or through regulations under clause 17, and it would set requirements for procurement, patient choice and competition. In effect, any deliberate attempt to vary the market share of a particular category of provider based on ownership or status would be unlawful.

That does not mean that there will be no competition for NHS services. The Future Forum stated that “if competition is used effectively and properly regulated, we do not believe it threatens the fundamental principle of an NHS that is universal and free at point of delivery.”

Owen Smith: I think that my hon. Friend the Member for Leicester West will come on to the substantive point to which the Minister has just alluded and the fact that there will still be competition—we think destructive competition—in the NHS. I would like to raise a potential unintended consequence of the provision. In future, the Secretary of State will be prohibited from encouraging the growth of the public sector, which seems a curious constraint. Will the Minister confirm that that is what is suggested in the explanatory notes and tell us whether he thinks that such a provision is sensible? It would, for example, stop the expansion of health care to take into account social care or other aspects of the public purse.

Mr Burns: If the hon. Gentleman bears with me, I will come back to that point during my comments. I want to repeat the quote that I have just given, because the intervention distracted the flow of the debate. As I have said, the Future Forum stated that “if competition is used effectively and properly regulated, we do not believe it threatens the fundamental principle of an NHS that is universal and free at point of delivery.”

Grahame M. Morris: Will the Minister give way?

Mr Burns: No I will not; I want to make a bit of progress, if the hon. Gentleman does not mind. As we will discuss when we debate clause 56, promoting competition will not be an end in itself: Competition will be about creating choice and driving up standards for patients, and there will be no hidden agenda concerning privatisation. The board, Monitor and the Secretary of State could still undertake action that has the effect of varying the market share of a particular sector, if carried out for some other reason. For example—this answers the point raised earlier—the board must have the freedom to commission services from the best providers, regardless of what sector they are in. The NHS does not have a monopoly on being able to meet patients’ needs effectively. There are strong examples of non-NHS organisations that provide high-quality care, for example through hospices. There are also examples where the NHS has not delivered high-quality care or has been poor value for money. However, the board could not commission services with the purpose of favouring one particular sector.

Grahame M. Morris: Will the Minister give way on that point?

Mr Burns: No, not yet. Similarly, Monitor could take enforcement action against providers that were in breach of their licence, even if those were of the same type. Although such actions may have the effect of varying market share, that is not their purpose. The amendments make it clear that Monitor, the NHS commissioning board and the Secretary of State should act in a neutral and even-handed way. The Government want the private and voluntary sectors to play their full part in improving quality of care and choice for patients, but we are not in the business of favouring one type over another; and we are absolutely not in the business of privatising the health service. I hope that the Committee will welcome the amendments and the reassurance that they provide.

Liz Kendall: The amendments are not a safeguard. Although I may be mixing too many metaphors, I think they are a fig leaf—and a confused one at that. The Government are trying to convince patient groups, staff and other professional bodies that they do not have a plan to increase private sector provision in the NHS. Yet, at the same time they want the right wing of their Back Benchers to think that they are still pushing ahead with competition and choice. They are trying to have it both ways, and the amendments do not convince anybody.

The heart of the Bill is that Monitor still exists as an economic regulator, and UK and EU competition law is still being enshrined in the NHS in primary legislation for the first time. We shall have a debate about whether Monitor is promoting competition or stopping anti-competitive behaviour, and whether it should be an economic or a sector regulator. However, the truth is that the heart of the Bill remains the same. The Government now refer to any qualified provider rather than any willing provider. The idea that there would be somebody willing but not qualified is horrific. However, the policy still remains. Amendment 75 says that no one should purposefully try to increase the proportion, which is in direct contrast to what the Prime Minister said when he launched his first attempt at public sector reform, in the long-awaited White Paper. He said this in The Daily Telegraph:

“We will create a new presumption...that public services should be open to a range of providers competing to offer a better service.”

There will be no presumption about the public sector providing.
Mr. Grahame M. Morris: The question that I want to raise relates to my understanding of what that means in practical terms. A particular example is the prison health service contract in the north-east of England, worth £56 million, which was awarded to Care UK. Is the assumption in the amendment that contracts such as that—which I understand faces difficulty in delivery—will never come back to the public sector?

Liz Kendall: My hon. Friend makes a good point, with an example from another public service. It seems that the Prime Minister—

Jeremy Lefroy (Stafford) (Con): Will the hon. Lady give way?

Liz Kendall: Let me finish my response to my hon. Friend, and then I will give way. On the one hand, the Prime Minister tries to convince people that he is pushing ahead with what he calls public sector reform, where everything is opened up to any willing provider and there is no longer a presumption that the state should provide. Yet, somehow with the NHS, that is not going to be the case. Amendment 75 states that

“The Board must not exercise its functions for the purpose of causing a variation.”

It does not prevent that from happening in the first place. The amendment will do nothing. It is a fig leaf—an attempt to convince people that their fears will not be realised. The other parts of the Bill will be much more powerful than this weak amendment in changing the way in which services are provided.

Jeremy Lefroy: To bring a bit of balance to the debate, national mental health care services for the armed forces are dealt with in my constituency of Stafford. They were previously the responsibility of the Priory Group, which is in the private sector, but the contract has been won by the NHS trust in Stafford. The contract has returned to the NHS, so these things can go both ways.

4.45 pm

Liz Kendall: I hope that that provides an excellent service for his constituents.

Jeremy Lefroy: It does.

Liz Kendall: We will address this issue in greater detail when we come to the clauses on Monitor and competition.

Grahame M. Morris: On the point made by the hon. Member for Stafford, is it not the case that, if we accept the amendment, such provision could not happen? Surely the existing public, private and voluntary sector provision could not happen under the arrangements.

Liz Kendall: I hope that the Minister will answer that question. It is not accurate for the Government to say that the amendment creates a level playing field for providers, because that is not what it does. It is important that the Government are accurate in what they say about what they are trying to do. A level playing field, as we discussed earlier, relates to a whole host of other issues, such as whether the private sector contributes towards training, whether the full costs of care are recognised, and whether there is equal access to commissioning bids among all different sectors. Later clauses will have a far greater and stronger influence than this clause on changing the make-up of providers in the NHS. This is an attempt to mislead people about the Government’s wider purpose and it is insufficient.

John Pugh (Southport) (LD): We are tasked with looking for unintended consequences in particular wordings. I warmed to the hon. Member for Easington, as I normally do, when he said that what we really need to look at is the practical, real-term consequences of the wording under discussion, as opposed to any other sort of wording. It is hard to gauge, because although we are ostensibly amending clause 19, we are also dealing in part with clauses 56 and 110. We will, therefore, probably have a larger and more thorough discussion on the issue when we get to the big debate on Monitor, which is on the horizon and will probably take place on Thursday.

I want to make a few remarks that might be helpful while not stealing the thunder of that debate. The amendments prevent Monitor from arguing for a fixed quantum of public or private provision, which I think most of us would regard—as an a priori principle—as a bad idea. Monitor is fundamentally tasked, as are most of the organisations with which we are dealing, with doing what is best for patients. None of us know which mix of public and private provision would be appropriate to actually do that. Monitor’s primary duty is to look out for patients and be mindful of the benefits of competition and integration, but it cannot take into account in advance any particular view of what would be the right level of public or private provision, particularly if it is going to adjudicate whether or not contracts are fairly handed out. It cannot pre-empt its judgment.

Owen Smith: The hon. Gentleman says that words matter, and he is absolutely right. He also says that the amendment is not about determining a fixed quantum of any one sector in the NHS, but is that really what it says? The actual wording in the three amendments is, “for the purpose of causing a variation in the proportion of services”, which seems to be a different concept. I agree with the hon. Gentleman about never being able to stipulate what the precise quantum of any one provider ought to be, but my worry is that it stops there being any shift from what we have at present.

John Pugh: Opposition Members are saying two different things. The hon. Gentleman has just said it stops any shift. A few minutes ago, the hon. Member for Leicester West said that the shift could take place regardless, and the hon. Member for Easington seemed to be under the misapprehension that it would stop a contract currently in the private sector going back to the public sector if that is what commissioners wanted to happen. If the critique is correct, one hon. Member has to be wrong.

Dan Byles (North Warwickshire) (Con): Is not this what we could term the agnostic clause, which simply states that the Government have to be agnostic about
the actual ownership of a service when making a decision? They should not be seeking to vary it. The amendment does not say that they cannot make a decision that leads to a variation; it simply says leading to the variation must not be the motive behind making a change.

John Pugh: I think that is the theory behind it. There is a sort of plausible contemporary view that the commissioners and health service should be, as it were, provider agnostic and indifferent. My suspicion is that they will not be indifferent; GP commissioners will tend to have a bias in favour of the public sector. My view is that there probably are good reasons for doing that, which need to be spelt out. One good reason, which no one has alluded to so far, is that if the choice of choosing 100% private sector means that the public sector fails, the public purse bears the cost of that failure, and therefore we cannot be absolutely and completely neutral. Any public provider is a public investment and lives by virtue of the public will, and we need to be mindful of it when we run the NHS. So, absolute provider agnosticism makes little sense. It also makes little practical sense.

There are certain retail outlets—supermarkets and so on—that sometimes use their own people and sometimes use a commissioned service. Safeway sometimes uses its own lorries and sometimes uses Eddie Stobart lorries. When it decides what to do, it has to think what to do with its own lorries at the end of the day, and therefore absolute provider agnosticism is not possible.

A perhaps more critical point is that commissioners in the NHS, unlike any of the private or voluntary providers, have to have a view with regard to long-term sustainability. They have to ask themselves whether a commissioning decision will lead to the long-term sustainability of services needed in their area. If the private or social enterprise is the peg upon which that is hung, we have to bear in mind that the private and the social enterprise is the peg upon which the sustainability of services needed in their area. If the private or social enterprise is the peg upon which that is hung, we have to bear in mind that the private and the social enterprise are there because they are promoters and supporters, and not necessarily because they have to be there. So the issue about long-term sustainability and the public provider being a public asset makes pure commissioner agnosticism, if I can put it like that, very difficult.

Liz Kendall: Opposition Members believe that the clinical and financial sustainability and viability of services is crucial, which is why we tabled the amendment we dealt with this morning. I noticed that the hon. Gentleman did not vote against it; he abstained. If he was so concerned, why did he not support that amendment rather than this mess of an amendment? We are not clear what it seeks to achieve.

John Pugh: I am convinced that the commissioners have the flexibility, within the remit of the legislation, to take into account all the factors that I have spelt out without falling foul of Monitor. Again, I do not want to pre-empt the big debate on Monitor, but my fear is that Monitor would prevent commissioners from taking important considerations—apropos sustainability and the failure of a service—into account. What we cannot have, and the reason why we have this particular clause, is a situation in which someone can commission a public service as a worse alternative, as something that is qualitatively worse than an alternative service. None of us could go out there and argue that the public should accept a public service that is second best, simply because it is a public service. That is why I think the clause is phrased as it is.

It is hard to see why public sector provision—if it is, indeed, inspired by public service ethos and unencumbered by any need to make a shareholder profit and if it exists on a level playing field, which is the crucial consideration that the hon. Lady has brought to our attention—should not, in most circumstances and when it chooses to do so, excel in its performance compared with the private sector. The Government are taking special pains—they should be given credit for that—to level the playing field. I am convinced that they intend and want to do that, and I hope that the legislation will succeed in doing that.

Mr Barron: There seems to be a lot of confusion about the exact purpose of the amendments. The greater problem is that the Bill, in terms of introducing competition law, remains unchanged and unaltered by the recent pause. Members will remember my interaction with the Secretary of State in the first sitting on the recommitted Bill, when I questioned him about the unaltered clauses 64, 65 and 66, which are the first three clauses that relate to competition. I will not read it all out, but I remind the Minister, who was sat next to him at the time, that his right hon. Friend said:

“In so far as Monitor will have licensing responsibilities, it will be able to exercise ex ante licensing provisions, the purpose of which is to support the NHS. As a consequence, that will make less likely the intervention of any competition provisions, which tend to fragment and distort what would otherwise be the NHS’s approach.”—[Official Report, Health and Social Care Public Bill Committee, 28 June 2011; c. 92, Q191.]

However, the clause that I and that the Secretary of State were referring to remains unaltered. Any merger between NHS trusts or merger between NHS trusts and other bodies—whatever that means—will be referred to the Office of Fair Trading and the Competition Commission. That is what destabilises the national health service. It destabilised it on the first day, and it remains destabilised in that way. Making amendments, which I certainly will not vote against, that suggest that that type of destabilisation could not happen, while those clauses remain in the Bill, is fundamentally contradictory.

I am not a lawyer, but, in response to his comments about mergers, I said to the Secretary of State:

“And not just have the OFT and the Competition Commission”, look at such issues. He replied:

“Exactly, but in so far as that is already the case, the OFT and the Competition Commission can look at such mergers.”

I interrupted with, “Do they?” He replied:

“They could do. They have not. Actually, there is no reason for us to suppose that they are likely to be because—”.

I then asked:

“Why put it in the Bill?”—[Official Report, Health and Social Care Public Bill Committee, 28 June 2011; c. 93, Q192-194.]

That question remains today and will remain throughout the passage of the Bill not only through the House of Commons, but through the other place. It potentially contradicts the amendments that I hope that we will make this afternoon.

I hope that the intention of the amendments is what it is said to be. As I have said on many occasions, I am not against the introduction of the independent sector, but the Government need to have a substantial rethink.
about the Bill and how it is constructed if we are to believe that there is no potential for such matters to be taken over by lawyers, instead of the current system where the Co-operation and Competition Panel looks at mergers. Such matters should be overseen by people who want to see proper mergers between NHS trusts and proper integration in our national health service.

Amendment 75 agreed to.

Mr Burns: I beg to move amendment 76, in clause 19, page 18, line 27, leave out ‘a significant’ and insert ‘an’.

The Chair: With this it will be convenient to discuss the following: Government amendment 78.

Amendment 8, in clause 22, page 31, line 12, leave out from second ‘are’ to end of line 13 and insert ‘fully consulted—’.

Government amendments 118, 119, 123 and 136.

Mr Burns: The amendments deal with the board’s and clinical commissioning groups’ duties in relation to public involvement and consultation. The Government amendments are designed to strengthen local arrangements for public involvement and consultation, responding to the recommendations from the NHS Future Forum. I will take the amendments in two sub-groups. The first sub-group includes amendments 76 and 118, which amend the public involvement duty on the NHS commissioning board and CCGs in new sections 13L and 14P of the 2006 Act by removing the word “significant”.

The NHS commissioning board and clinical commissioning groups are currently required under new sections 13L and 14P to make arrangements to secure that the public are involved first, in planning commissioning arrangements; secondly, in developing and considering proposals for changes in commissioning arrangements; and thirdly, in decisions affecting the operation of commissioning arrangements. These sections are modelled closely on the existing duties on primary care trusts and strategic health authorities in section 242 of the National Health Service Act 2006.

5 pm

As the Bill stands, the board and CCGs would be required to involve the public only in proposals for changes in commissioning arrangements that would have a significant impact on the manner in which the services are delivered...or the range of health services available”. The rationale for this was to avoid unnecessary or disproportionate burdens on commissioners. However, Future Forum and a number of charities that responded to the listening exercise raised concerns that that could restrict the scope for public consultation on major service changes and create questions about what would count as a significant change. Responding to these concerns, we have introduced the amendments to remove the word “significant” and to bring the duties into line with the current section 242 duty in the 2006 Act.

I hope that those changes reassure Opposition Members that amendment 8 is not required. I understand that the intention behind that amendment is to ensure increased involvement of individuals who are receiving or may receive NHS services in the planning and development of commissioning arrangements. That is a similar amendment to one that we debated during the first Bill Committee proceedings, which the hon. Member for Islington South and Finsbury withdrew. As I said, the drafting of new sections 13L and 14P follow the existing wording in section 242 of the 2006 Act by stating that individuals may be involved “whether by being consulted or provided with information or in other ways”.

That provides flexibility for commissioners to decide on a proportionate course of action in involving the public, depending on the significance of the proposed service change. It is important that they can exercise that judgment and that is why we tabled amendments 76 and 118.

The Bill also provides a power, in new section 14P(3), for the board to issue statutory guidance to CCGs in relation to this duty, to which they must have regard. That could be used to make clear the importance of proportionality and to provide examples of it. That flexibility is there for a very good reason: to ensure that CCGs can act proportionately in involving patients and service users. I think we would all agree that a 12-week consultation on, for example, changing the time of a surgery by 10 minutes would be wildly disproportionate. I hope that removing the word “significant” from new section 14P to bring the duty fully into line with the current duty in the 2006 Act satisfies the general intention behind amendment 8 and the concern previously expressed by the hon. Member for Islington South and Finsbury that the duty, in being fulfilled, “may simply result in a leaflet on a desk”—[ Official Report, Health and Social Care Public Bill Committee, 8 March 2011; c. 534.]

Turning to the second sub-group, amendment 119 is an important amendment that responds to the recommendation by Future Forum that the board should place particular emphasis on the plans that prospective CCGs have for involving the public when considering applications for authorisation. It would require CCGs to include in their constitutions a description of the arrangements they have made to fulfil their duties under new section 14P in respect of public involvement and consultation and a statement of the principles that they will follow in implementing those arrangements. The board would need to be satisfied that a prospective CCG’s proposed constitution is appropriate in that respect when considering its application for establishment under new section 14C. We also intend, Opposition Members suggested, in the spirit of helpfulness, in the first Committee proceedings, to amend the provision both for CCGs’ commissioning plans and for their annual assessments.

Amendment 123 will require CCGs to explain in their annual commissioning plans how they propose to discharge their duty under new section 14P to involve and consult the public, in addition to the current requirement that they explain how they propose to discharge their duty under new section 14L to improve the quality of services. The Bill already requires that a CCG’s annual report must explain how it has discharged its duty to involve and consult the public. Amendment 136 will require that, when the board conducts a performance assessment of each CCG in respect of each financial
year, under new section 14Z1, it must now also consider how well the CCG has discharged its duties under new section 14P.

Related to those changes, amendment 78 will require the board to explain in its annual business plan how it proposes to discharge its public involvement duty under new section 13L, in addition to explaining how it proposes to discharge its duty to improve quality under new section 13D. Amendment 78 also requires the board to explain in its business plan how it proposes to discharge its financial duties under new sections 223D to 223DB. The amendment brings the board into line with the requirements on the annual commissioning plans of CCGs.

As I have already mentioned, this suite of amendments is designed to strengthen local arrangements for public involvement and consultation, as recommended by the Future Forum. I hope that the Committee welcomes the amendments and that they satisfy the concerns expressed by the hon. Member for Southport, which arise from his role as chair of the all-party group on patient and public involvement in health and social care.

I commend amendments 76, 78, 118, 119, 123 and 136 to the Committee. I am confident that the hon. Members for Islington South and Finsbury and for Leicester West will accept that we have made sufficient provision and will not press amendment 8.

Liz Kendall: Finally, the Minister has thanked us for tabling all of those amendments during the original Bill Committee. When we said that the requirements on patient and public involvement were not enough, we were ignored and our amendments were rejected. I am glad that, at least on this clause, the Minister has seen the error of his ways.

I have one plea and a series of questions. The plea is that the Minister does not fall into the trap of my esteemed former colleagues at the Department of Health by talking about suites of policies and amendments—language which is incomprehensible to the public and staff.

Mr Burns: I am trying to please the hon. Lady.

Liz Kendall: I have no desire to talk about that now. I am pleased that the Minister gave an example of a not significant change in service, such as a GP surgery proposing to change its opening hours by 10 minutes. He is not usually keen on giving examples; now that he has opened the door, will he answer some other questions?

This is a serious point. The Minister has removed the requirement that GPs need only consult on significant service changes. Does that mean that GPs will have to consult patients and the public if a bay in a hospital ward closes, if a whole hospital ward closes, or if out-patient appointments for dermatology, which have been discussed today, are shifted out of hospitals and into the community? Would a GP service have to consult if it decided to provide a different form of district nursing, swap a well woman clinic or stop running smoking cessation services? A number of people who have rightly asked whether GPs might now be required to consult on every single change. To keep it simple, as the Minister likes it to be, will he say whether they have to consult on the closure of a hospital ward?

Mr Burns: I am a teeny-weeny bit hurt by the hon. Lady’s comment about my reference to a suite of amendments. I was doing it to be kind to her because I too have Leicester Liz as one of my favourites. She was talking about this over the weekend, so I thought that if I made her feel comfortable by using the terminology of her tweets, she would support the amendment. It just goes to show that there are no thanks in politics, and I did not get any today. Having said that, I am glad that she and her hon. Friends seem to welcome the amendments. Having listened to the Future Forum, I am sure that they will strengthen and improve the Bill.

The hon. Lady has also raised a number of individual examples, ranging from very significant to less significant, but not as insignificant as the example I deliberately picked so as to illustrate the purpose. As the hon. Lady knows, there is guidance on how PCTs should take these decisions and the board will provide similar guidance for clinical commissioning groups in due course. I think that we can guess that on some of the examples that she gave, the answer will be yes. I do not want at this stage, for historical reasons and others, to commit myself on every single example that she gave, but certainly guidance will be provided that will clarify the situation. For those reasons, I hope that hon. Members will accept these amendments.

Amendment 76 agreed to.

The Chair: The Minister says that there are no thanks in politics. Let me encourage him by saying that the day is not over yet.

Liz Kendall: I should make it clear that we will not press amendment 8, Dr McCrea.

The Chair: I appreciate that.

John Pugh: I beg to move amendment 228, in clause 19, page 19, line 2, leave out from ‘available’ to end of line 3.

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

Amendment 229, in clause 19, page 22, line 38, at end insert—

(i) the disclosure is necessary or expedient for the purposes of patient safety.’.

John Pugh: This is a probing amendment, so I will be relatively brisk. New section 13M(1) of the National Health Service Act 2006 states:

“The Board must establish and operate systems for collecting and analysing information relating to the safety of the services provided by the health service.”

Subsection (2), which I would amend, says:

“The Board must make information collected by virtue of subsection (1), and any other information obtained by analysing it, available to such persons as the Board considers it appropriate.”

I am, as it were, depriving the board of discretion by simply deleting the words after “available”. New section 13X lists a series of regulations about disclosure of information by the board. The circumstances listed include “if... the disclosure is necessary or expedient for the purpose of protecting the welfare of any individual.”
I would add:

"the disclosure is necessary or expedient for the purposes of patient safety."

Patient safety is a paramount consideration for us all. I am chair of the Patients Association all-party group, and this is very much on our agenda. It is clear that there is a long history on this subject. In the past, information on risks and clinical safety has been not only not disclosed, but at times covered up. One thinks of the Mid Staffordshire and Bristol cases, and one thinks of the fate of whistleblowers. Over the weekend, The Independent made quite a deal about the fate of whistleblowers, which was not encouraging.

5.15 pm

I accept that no service is risk-free and that judgments on safety are sometimes best made by informed opinion, but our concerns have been accentuated by the abolition of the National Patient Safety Agency under clause 274. I understand the argument for that, because the Minister expressed it relatively clearly in our first thrashing out of the Bill. He suggested that the NPSA was simply being brought in-house to allay concerns about conflicts of interest with the national commissioning board, within which it is hosted, and that there would be a Chinese wall between the section of the national commissioning board that deals with reporting patient incidents and safety and the bit that does the commissioning. The general function and objective behind it was to embed safety in NHS culture, and I think we all applaud that. En passant, clause 274 also changes the NHS Redress Act 2006. I served on that legislation, and I am not certain to what extent it is implemented or in force today. We might want to revisit that territory.

The current NPSA website has a series of protocols about disclosure, freedom of information and transparency and a scheme for publication of data. The agency put a very clear, overt and explicit system in place, which one assumes would be replicated in part within the national commissioning board. The board is also a commissioning body, however, as opposed to a source of useful information on breaches of patient safety. It strikes me that in the process of commissioning and monitoring contracts, the board will acquire genuinely interesting information about the risks of the service, but such information would not necessarily be formally available to whatever branch of the national commissioning board replicates the NPSA, because, as the Minister says, there will be a Chinese wall between the two. That is why I am slightly concerned that the national commissioning board is free to decide on the appropriate person to whom information on patient safety may be disclosed, or rather I will be concerned until the Minister has expanded on that clause.

It may not be service users who have the biggest interest in knowing which of the services that they are using are safe. In some circumstances, the national commissioning board may not want fully to disclose information about the safety of individual services. That may be, first, because of a breach of contractual confidentiality that might occur from time to time, or breaches of contractual confidentiality may be implicated in disclosure. Secondly—as the hon. Member for Leicester West said when we first discussed clause 274—clinical

Owen Smith: In a very interesting speech, the hon. Gentleman has sparked a thought in my mind that has not occurred to me before. I wonder whether he shares my concern about whistleblowers. Under the Bill, clinical commissioning groups, as they are to be known, will have licence to set staff terms and conditions, and there may be arms of commissioning groups that are in the private sector or at longer arm's length from the NHS. Is the hon. Gentleman not concerned that there might be less freedom for individuals working in the new architecture to raise concerns? There might even be contractual obligations on them not to do so.

John Pugh: I have mentioned that concern, but the hon. Gentleman has given me cause to reflect. The Secretary of State himself has mentioned that clinical safety is not necessarily dealt with in the health service. Clinical safety considerations are often muddled up with other issues, such as financial viability, and in many configuration decisions pleas based on clinical safety are often founded in a different sort of consideration. The different considerations get enmeshed, and clarity and transparency are the obvious antidote.

Mr Barron: The hon. Gentleman raises a good point. In the previous Parliament, I sat on a Select Committee that considered patient safety and produced a report. On whistleblowing, we thought that there were a number of great weaknesses in the system. On occasion, whistles are not blown, as in the Mid Staffordshire case, on which we took evidence. In the recent atrocious events in a care home, we see a situation in which the whistle was blown but ignored by people who should have known better. The Health Committee in the previous Parliament recommended that we should have a statutory body very much like the one in New Zealand, so that anyone, no matter what their contractual relationship with the health service, and whether they are a patient or not, can go to that body, which can investigate, sometimes anonymously so that the careers of people who want to alert the establishment to patient safety issues are not threatened.

John Pugh: I am sure that the Minister would welcome such a policy proposal. My question is simpler. How do we establish that all information about clinical safety held by the national commissioning board is properly available to users and other relevant parties, without causing undue alarm
and without leaving that decision solely to the discretion of the board? Although there might be a Chinese wall between the two compartments of the board, I would be much relieved to know that the transmission of information through it went both ways. I am certain that if something is reported to the NPSA arm of the national commissioning board, it will be passed to the commissioners, but if the commissioners chance upon something regarding the safety of services they commission, certain interests they have might mean that they do not go for full disclosure. That is my concern. The amendment is a probing one, and I will welcome the Minister’s comments.

Mr Burns: As all right hon. and hon. Members will appreciate, patient safety is of the utmost importance and is at the heart of a modernised NHS. The Bill aims to embed patient safety across the whole of the NHS, for example through placing the definition of quality, which includes patient safety, in legislation for the first time. I thank the hon. Member for Southport for raising a number of interesting and valid points, and I hope to reassure him with my comments.

Amendment 228 would require the board to make information it collected on patient safety and its resultant analysis more widely available to such people as it considered appropriate. The hon. Gentleman is absolutely right that information that can inform and enhance patient safety in the NHS should be made available to everyone who would benefit from it. The public are also entitled to know how the NHS is performing on patient safety.

The clause requires the board to make appropriate information available to any person it considers appropriate and to give advice and guidance to the NHS. If the board did not make important information available to people it thought could reasonably benefit, it would be in breach of its duty. For instance, the National Patient Safety Agency currently collects and analyses information on safety incidents in the NHS, using the national reporting and learning system, and provides solutions to safety issues that are identified. It then disseminates alerts or guidance on urgent patient safety issues to the NHS through the central alerting system. Those responsibilities will move to the NHS commissioning board, covering the whole function, from compiling the evidence, using issuing alerts and providing overall national leadership for safety and quality improvement.

Our intention is to bring that function under the responsibility of the commissioning board to create a more direct link between learning from patient safety incidents and reflecting that in how the board exercises its commissioning functions, and, for example, the guidance it will produce for clinical commissioning groups. We believe that that will enhance our efforts to embed a culture of patient safety in the NHS. In addition to NHS bodies, that information is currently also used to develop products for use by non-NHS organisations, the devolved Administrations and international organisations. The ability to share more widely allows the board to make the judgment as to who else could benefit from the information and to recoup the costs of doing so while maintaining protections around confidentiality. However, we would not want to remove the discretion for the board to determine when it would be appropriate to provide such services.

The amendment would also have the unfortunate effect of creating a greater obligation for the board to make available all the information it gathered in relation to patient safety, much of which is sensitive, confidential and identifiable to individual patients. Notwithstanding the protections offered by the Human Rights Act 1998 and by data protection Acts, it remains important to provide some parameters for the board as to whom it could share that information with. That would be difficult to stipulate in legislation, which is why the clause allows the board to use its judgment about what should be made available, and to what audience.

Amendment 229 would provide powers for the board to disclose information under section 13X for the purposes of patient safety. Once again, the hon. Member for Southport makes an important point: the board should not be prevented from disseminating important information that could help prevent a situation in which patient safety is jeopardised. I hope that I can reassure him on that point. Subsection 1(d) goes some way to addressing that, as it allows the board to disclose information when that is necessary to protect an individual’s welfare. There may, of course, be incidences where the board may disclose information on any potential threat to patient safety in order to prevent it from materialising. However, in that case, the disclosure could be covered under subsection 1(f), as being for the purpose of facilitating the exercise of the board’s patient safety functions under section 13M.

It is our intention that the board should be able to disclose information where that would be in the interest of patient safety. However, I am prepared to look again at the clause to see if there is a need for the wording to be made more explicit in that regard. I hope that that reassures the hon. Gentleman and that he will agree to withdraw his amendment.

John Pugh: I thank the Minister for that full and helpful response. I now realise that if I persist with my amendment I will be in breach of the Human Rights Act 1998. Tempting though that is, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Mr Burns: I beg to move amendment 77, in clause 19, page 19, line 15, at end insert—

‘( ) Arrangements made under subsection (7) do not affect the liability of the Board for the exercise of any of its functions.’.

The Chair: With this it will be convenient to discuss Government amendments 80 and 120 to 122.

5.30 pm

Mr Burns: I move to amend Chapter A1, which is to be inserted in Part 2 of the National Health Service Act 2006 by clauses 19 and 20, and Chapter A2, which is to be inserted by clauses 21 and 22, with five minor and technical amendments with a common purpose—to ensure that when a commissioning body, either the NHS commissioning board or a clinical commissioning group, exercises a function jointly or delegates it to another commissioner as allowed by terms of the Act, it does not affect the liability of that commissioner for its statutory functions.
One of the strengths of the proposed new arrangements for commissioning is the way in which they will facilitate collaborative working between different organisations. Individual clinical commissioning groups will be able to join together, with suitable risk-pooling arrangements and sharing of budgets, to commission more effectively low-volume but high-cost treatments. The Bill gives CCGs the flexibility to adopt a lead commissioning model for large providers. Such models will allow effective management of the interests of a larger number of CCGs, not only in the design of services and contracting, but also in any major reconfiguration. The Bill also contains a power for regulations to provide CCGs to exercise particular functions jointly with Welsh local health boards in cross-border areas. In those instances, the regulations may provide for any such functions to be exercised by a joint committee of the NHS commissioning board and the CCG.

Liz Kendall: Is the Minister saying that the measure partly relates to a CCG taking the lead on commissioning services for a range of other services, as primary care trusts did in commissioning ambulance services, for example?

Mr Burns: Yes, I am saying that. I hope that is helpful to the hon. Lady.

Similarly, the NHS commissioning board may exercise functions jointly with, or delegate its exercise to, special health authorities, CCGs or other prescribed bodies to ensure that the right arrangements are in place at the right times for commissioning the services for which it has responsibility, and ensuring that it exercises appropriate oversight of the NHS. Among the commissioning board’s responsibilities, it must ensure that it has systems for collecting and analysing information relating to the safety of services, which it might delegate to an individual or another NHS body, which allows it to exercise the right expertise and capacities.

The amendments will ensure that in all such forms of collaboration, joint working and delegation of function, the liability of the board or CCG remains unchanged. Functions and activities might be delegated, but the liability—the statutory commissioning responsibility that is placed on both board and the CCGs—cannot be delegated or transferred to another body or individual. That safeguard is necessary, not least to preserve confidence in the NHS among patients and professionals who have voiced concerns and misconceptions that general practice-led commissioning consortia might outsource their commissioning functions and, effectively, abdicate their responsibility to patients. That is clearly not so, and it was never the policy intention. However, the amendments establish in the Bill the principle that responsibility for statutory functions cannot be transferred and remains vested in the commissioning organisation.

Liz Kendall: This is an important group of amendments. When the original Bill was in Committee, the Opposition raised, several times, real concerns about GP consortia, as they were then called, delegating their essential commissioning functions to the private sector. The Government denied that that would be the case; they denied that the Bill needed changing; and now, once again, they have seen the error of their ways. I am slightly disappointed that they did not thank us for our foresight and the work that we put in last time.

Mr Burns: Before the hon. Lady claims too much credit, I drew attention to a few words she has said when I concluded my remarks. To paraphrase, she said that it was never the intention to make the change, but that the Opposition thought it was proper to put it in the Bill to put an end to misrepresentations and misconceptions.

Liz Kendall: The only people who have got themselves into trouble over the Bill are the Government. They got the wrong policy, and it is not just that they failed to communicate it. Their policies were not misrepresented; when people understood the Bill they saw what the Government were trying to do. [Interruption.] As my hon. Friend the Member for Islington South and Finsbury says, they were rumbled.

I am looking forward to getting the Minister’s letter, which I hope will come later today, or tomorrow. It would be helpful to have it because, as I said last Thursday, we have seen reports that primary care trusts are already delegating responsibility for commissioning—including prescribing and out-patients appointments—to private sector organisations. I am concerned about what safeguards are in place.

Owen Smith: I know that my hon. Friend will forgive me if I anticipate what she was about to say next. Is it not the case that what the Minister just said—and our understanding of the amendment—is that all the amendment does is make clear that the legal liability still rests with the commissioning group? In operational terms it may still delegate all of the commissioning functions to a private company at arm’s length. It may pass off whatever it likes—that is cleared by the Bill—but ultimately it will be responsible.

Liz Kendall: My hon. Friend is right to raise that point. All that the amendment does is clarify the law as it stands. There are very real concerns about chunks of commissioning being outsourced to the private sector.

Mr Burns: Will the hon. Lady give way so that I can help her?

Liz Kendall: At this stage I do not need the Minister’s help. He can reply later. If he thinks that what I have said is wrong he will be able to do that when I have finished making my comments. I think that people are still concerned about what checks will be in place if whole commissioning functions are outsourced. They are concerned about how bodies will be held to account for those decisions by patients and the public. I am sure that Members of the House will want to know how they will know when a whole set of commissioning functions have been delegated or outsourced. Crucially, how will we assess the impact on patient care, which is what all of this is about?

I think that the Government will spin this as a major change in the legislation, as on so many occasions before, but Opposition Members will not be convinced. The Government might try to say to the members of the
Future Forum that they have done so; we have the great joy and pleasure of actually reading and scrutinising the amendments, and seeing that they do not provide the level of protection that many in the Future Forum think the Government have committed to providing.

John Pugh: The hon. Lady draws a distinction between the actual commissioning—the decision-making process itself—and activities preparatory to commissioning. I assume that she is not saying that commissioning consortia cannot use the private sector to do anything, so she therefore acknowledges that they can do something. At what point would the hon. Lady draw the line and say, “These are the things with which the private sector cannot be involved, or which cannot be outsourced”? It is not at all clear where the line can be drawn if the commissioning itself will be done by a public body.

Liz Kendall: I think that people will be very concerned if whole sections of commissioning can be outsourced to the private sector. That was the concern raised by the Future Forum. The point that I am making in scrutinising the Bill is that, in the Government’s response to the Future Forum, they convinced people that that would not be allowed to happen. The amendment does not prevent it from happening, which is the impression that the Government have given. It does not match up to what was said and many members of the Future Forum and the wider public will be concerned.

Owen Smith: I rise to suggest that the hon. Member for Southport has misunderstood what we are saying. We are saying that the amendment will not change proposed new subsection (7), which states:

“The Board may arrange for any other person (including another NHS body) to exercise any of the Board’s functions under this section”,

including its principal function of commissioning. All it says is that even if the board hands off any of its most important functions to a third party, the commissioning group will ultimately retain legal liability. I would have thought that that was a statement of fact. The analogy that I would draw is that if a bank decides to outsource to the other side of the world responsibility for providing advice from its call centre, the bank is still responsible for the advice given, but that does not mean that the recipient of the advice will be happy with the service received.

Liz Kendall: My hon. Friend puts it extremely well. My point is that the Government have given the strong impression since the listening exercise that that would not happen. They have committed to ensuring that services, and public functions such as commissioning services, are not privatised. The amendment will not prevent that; it only says that ultimately, commissioning groups will retain legal liability. That is not what the Government suggested they would do, and the Opposition will certainly be working hard to ensure that professional bodies, patients’ organisations and others know that the amendment does not change the current situation.

John Pugh: I wish to comment briefly on that, as the same points were made to me by Dr Evan Harris, and I have taken some pains to be clear on the subject. Somebody who works for me on an occasional basis also does commissioning for a PCT, and the other day I got her to sit down and tell me what sort of things she did during her day that counted as commissioning activities. She described a whole range of things, and all of them were things that are sometimes outsourced in a local authority without invalidating in any way the propriety of what the local authority does.

I have tortured myself about the question that the hon. Lady has not answered. She recognises and acknowledges that that decision making will ultimately be done by a public body based on open discussion among its members about what to do, that it will be examined by a health and well-being board, that it is therefore a perfectly overt and transparent process and that a range of other things might therefore be done within a commissioning organisation, most of which will have to do with commissioning and some of which she thinks can be outsourced, but she has proved incapable of drawing the line differentiating those activities that can be outsourced by a commissioning organisation from those that cannot.

Liz Kendall: With the greatest respect to the hon. Gentleman, who I know is under considerable pressure from Dr Evan Harris, it is not my responsibility to draw the line. The hon. Gentleman and Members opposite are in Government, unfortunately, and it is their role to draw it. He has confused two issues. One is the decision-making process. According to the amendment, that can still be outsourced to the private sector. The amendment specifies only that legal liability remains. Where is the clause that says that health and well-being boards can call in the private sector commissioners to question them about their decisions? It says that they can call in providers of services to examine what they are doing—that is a new addition to the Government’s plan—but not the commissioners. With the greatest respect to the hon. Gentleman, to whom I always listen, those questions are more for his party and the Government than for ours, because it is their legislation.

John Pugh: The hon. Lady says that she cannot draw the line. I am arguing whether anybody can draw the line in any meaningful way. Ultimately, decision making is a public affair. It should be publicly examinable and publicly tested in the same way as it is in a local authority. My local authority’s department of finance happens to be outsourced to Capita. I regret that, but it does not alter the nature of the decision-making process or create any particular perils.

5.45 pm

Liz Kendall: It is the finance function the hon. Gentleman is talking about. It is not the decision about—

Mr Burns: Yes, finance.

Liz Kendall: The Minister says, of course, finance from a sedentary position. That is not the same as the decisions about the future shape of all services. They are quantifiably different.

John Pugh: I was only going to make a brief speech. If I get interrupted anymore it will be a long speech. I am sure that the Minister will explain clearly that ultimately the decision-making function will be done by a public body.
end insert—

page 20, line 39, at end insert—

happen.

can not provide all the services that the CCG is required to
different organisation and arrange for that organisation
CCG could not transfer its commissioning budget to a
commissioning functions to a private company is no. A

term "private sector commissioners" is not helpful because
that CCGs could outsource their commissioning functions
to a private company. I have to tell her that using the

No. I will not. The hon. Lady has failed
to differentiate those other activities that can legitimately
be outsourced from those that cannot.

Mr Burns: I will be very brief because I have listened
to the exchanges between the hon. Members for Leicester
West and for Southport. Let me explain the matter.
CCGs always remain responsible for their functions. Yes,
you can get support in how those functions are
exercised, as PCTs can do at the moment. However, the
final commissioning decisions remain with the CCG.
The hon. Lady has asserted on a number of occasions
that CCGs could outsource their commissioning functions
to a private company. I have to tell her that using the

Mr Burns: These amendments, which relate to powers
similar to those of the commissioning board and clinical
commissioning groups, may have been prompted by a
misunderstanding. The provisions that the amendments
seek to amend are based on powers currently possessed
by the Secretary of State and PCTs under section 21(5)
of the 2006 Act, which was introduced by the previous
Government.

Those powers play a valuable role. They allow the
NHS commissioning board and CCGs to raise additional
income for improving the health service through various
means. I urge Opposition Members to listen carefully to
this, so that they do not misunderstand. Those means
include selling goods—for instance, assets in the possession
of a CCG such as vehicles; dealing with land if it is
surplus to requirements; the provision of training and
development to, for example, another clinical commissioning
group; or marketing their intellectual property, for example
by developing and selling computer software for analysing
local demand. Any income raised through these means
would be reinvested in the health service.

Those powers would not—I repeat not—allow the
board or clinical commissioning groups to charge patients
for services that they receive from the NHS, or to
otherwise charge for work conducted in the exercise of
their commissioning duties. I will repeat that, because
the hon. Member for Leicester West unfortunately did
not hear it, and it is a critical part of my speech. They
would not allow the board or CCGs to charge patients
for the services that they receive from the NHS, or
otherwise to charge for work conducted in the exercise
of their commissioning duties. I think that that is perfectly
plain, although I suspect that the hon. Lady still does
not see it in that light.

Grahame M. Morris: The Minister has taken pains to
explain the categories of assets that would be covered.
However, I draw his attention to a report from the
Bureau of Investigative Journalism. It has identified
£630 million of costs to the NHS, with GPs securitising
their premises and then hiring them back. Would that
be prevented under the Minister's proposal?

Mr Burns: I am not quite sure where the hon.
Gentleman's question is leading. So as not to trip up, I
shall give the caveat that the examples that I gave were
illustrative so as to draw out when a body might raise
funds by disposing of items that were surplus to
requirements, such as vehicles, land and so on. It has
nothing to do with charging patients for care. I am
trying to repeat in the clearest, loudest terms possible
that that does not include introducing charges for patient
care. I do not think there is anything to argue about; it is
quite clear cut. Charging by commissioners in exercising
their duties is prevented not only by the exclusion of

end insert—
such powers from the Bill, but by separate regulations governing the application of charging patients, which expressly prevent any charging except in permitted circumstances, which is a long-established principle, such as prescriptions, dental care and hospital care for overseas visitors in certain circumstances.

We have also made clear our continuing commitment to the NHS constitution and the rights and values it enshrines, including the principle that NHS care is available free at the point of use to all those eligible to use it. As we have already discussed, we intend to introduce a new statutory duty for the commissioning board and CCGs to act with a view to securing health services provided in a way that promotes the NHS constitution, including raising awareness of it among patients, staff and the wider public, for example when consulting on commissioning plans. That means that now, more then ever, patients will know that the NHS they know and love is safeguarded for the years ahead.

The amendments would limit how the board or CCGs could exercise their new powers, presumably to ensure that such activities do not impinge on their duties to patients through the introduction of guidance. However, the Secretary of State has already published guidance specifically on the powers to generate income, which applies to NHS bodies, including PCTs. Further to that, he can update the guidance to the commissioning board and CCGs under his general powers in section 2 of the National Health Service Act 2006, as amended by paragraph 1 of schedule 4 to this Bill. There are therefore adequate safeguards to govern the exercise of the powers. In fact, I would argue that they are more than adequate.

In the clause in question, there is a legal duty on both the board and CCGs to exercise the power only in so much as it does not interfere with the performance of their statutory functions.

I assure hon. Members that there are sufficient checks and balances in place to ensure that the powers pose no threat to the bodies’ fundamental role as commissioners of NHS services. Monitor will have a role in overseeing the transactional behaviour of the commissioning board and clinical commissioning groups. The board will have to undergo ongoing assessments of the commissioning groups’ performance. We have also set out a coherent framework in the Bill for monitoring the financial performance of a CCG and holding it to account through the accountable officer. In addition, the Secretary of State can update the guidance on the powers to generate income to apply it to the commissioning board and CCGs or issue new guidance under the powers granted to him by the Bill.

Requiring the Secretary of State to publish guidance on how the commissioning board and CCGs should use the limited powers they have to raise income would not create safeguards greater than those already in the Bill. It is wholly unnecessary, so I cannot accept the amendments. I hope that, on reflection and based on my assurances, the hon. Lady will withdraw her amendment.

The Chair: I would like to be helpful to the Committee. Members know that proceedings up to and including schedule 3 must end at 8 pm tonight. There is still a great deal of business to go through, but it is appropriate for members to have a short comfort break, if that is possible. Therefore, I propose a 10 minute break when we finish dealing with this amendment. If there are Divisions in the House before 8 pm, I am required to suspend the Committee for 15 minutes and there is no injury time. The deadline is 8 pm and I urge Members to remember that when they make their contributions.

Liz Kendall: Thank you, Dr McCrea. Your consideration of our comfort is much appreciated.

I have two points in response to the Minister’s comments. He will remember that on many occasions during the previous Committee, he reassured Opposition Members that our concerns were nothing to worry about. Monitor promoting competition in every part of the NHS whether or not it was appropriate was nothing to worry about. Strong requirements on Monitor, the board and commissioning groups to promote patient and public involvement and ensure that they included the views of clinicians were nothing to worry about. Education, training and emergency service planning were nothing to worry about, nor were any of the issues that in fact the Future Forum said we were right to be concerned about. He will therefore not be surprised to hear that I do not take his reassurance to colleagues at face value.

6 pm

We have concerns. They relate to a clause—I hope that Dr McCrea will not mind my saying this—that we did not discuss last week because the Government have not given us enough time. I am referring to clause 10, which deals with the power of consortia. It states: “Each…consortium may arrange for the provision of such services or facilities as it considers appropriate”.

If I had had the chance to discuss that clause, I would have said that that provision was not strong enough to guarantee a comprehensive service.

There are additional concerns that clause 19 could give consortia the ability to generate additional income by charging, not least because of the experience in my own area, where a GP has indeed called for that to happen.

On that basis, and in the spirit of getting us all off to our comfort break, I would like to press the amendment to a vote.

Question put. That the amendment be made.

The Committee divided: Ayes 11, Noes 13.

Division No. 10]

AYES

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

NOES

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

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

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

Question accordingly negatived.
The changes would ensure that the Secretary of State’s powers of intervention for the board are used appropriately, with proper transparency, while preserving Ministers’ ultimate accountability for the NHS.

**Liz Kendall:** I want to ask a brief question. The Minister, once again, gave a helpful example of something that the Government would consider the board to have failed on—if it had failed to give money to a clinical commissioning group. Is failure confined only to matters of allocating resources? Would it be a significant failure if the board did not deliver one of the many objectives outlined in the document that we referred to earlier? If the board did not achieve the outcomes specified under the mandate, would that qualify? Would it be a significant failure if the board did not fully consult patients and the public? How about if certain equality indicators were not met?

The trouble is that within the Government’s context, they say that they want the board to be independent and that they will intervene only if there is a significant failure. We have no idea what the Government consider a significant failure of the NHS board to be—or should I call it NHS England now?

**Mr Steve Brine** (Winchester) (Con): For goodness’ sake!

**Liz Kendall:** I am only repeating the words of the chief executive of the NHS in England. If the hon. Gentleman disagrees with that title, he should mention that to his Minister. Will the Minister give me more information about what a significant failure of the board would look like and whether any further information about that will be published?

**Mr Burns:** May I first answer the initial point that the hon. Lady made about whether this intervention was solely restricted to finances? The example that I gave was about the board’s failing to provide funding for a CCG. The short answer is no. It is not restricted solely to financing, but I am not going to speculate as to what it may be; that is consistent with the view that I take when being tempted down dangerous paths by the hon. Lady.

**Dr Daniel Poulter** (Central Suffolk and North Ipswich) (Con): Would my right hon. Friend agree that throughout the public sector over the past 10 years there have not been proper mechanisms to deal with failure, particularly where management has failed? That was brought out by Professor Corrigan at a recent meeting in the House. My right hon. Friend will be aware that Professor Corrigan was Tony Blair’s special adviser on health.

**Mr Burns:** I am grateful to my hon. Friend. As I said earlier, I will not be tempted through a whole range of examples, although his intervention was extremely helpful.

**Liz Kendall:** On a point of order, Dr McCrea. Is it right for a Minister to refuse to give any practical example to any question that Opposition Members raise? The last time that the Minister responded directly, he got himself into trouble over A and E. It is difficult for Members to scrutinise legislation when they ask practical questions and the Minister refuses to answer.
Secretary of State to impose certain limits on the board's commissioning groups. It also provides powers for the its functions, including providing funds to clinical would fund the NHS commissioning board to perform for the overall spend by NHS commissioners. In future, funds and setting spending limits for individual clinical commissioning groups. That differs from current arrangements, under which both SHAs and PCTs receive funding directly from the Secretary of State, who has wide powers of direction as to how the funds are used.

Amendments 89 to 93 would mean that the expenditure limit set for the board by the Secretary of State under proposed new section 223D would apply to total expenditure by NHS commissioners, including clinical commissioning groups. The board will be responsible.
for exercising its functions in relation to clinical commissioning groups to ensure that expenditure remains within that limit.

6.30 pm

Amendment 94 would introduce new sections 223DA and 223DB, replacing the current duties on the use of resources. Amendment 88 would remove a single overall resource allocation; instead there would be two resource limits, one in relation to revenue and another for capital. As with the expenditure limit under proposed new section 223D, those limits will apply to the total use of resources by both the commissioning board and clinical commissioning groups. The Secretary of State will continue to have powers to specify which resources, and which uses of resources, may or may not be taken into account for the purpose of those limits. That will provide clarity about what would score in each case.

Proposed new section 223DB provides powers for the Secretary of State to set additional controls on the use of resources. Rather than a cash limit on administrative expenditure by the board, as under current arrangements, the amendments would allow the Secretary of State to set a limit on the total use of resources for administrative matters by all NHS commissioners and a limit on the board’s own use of resources for those purposes. It is still our intention to create, for the first time, a fixed definition of the costs that will be covered by the limits on administrative expenditure in regulations. Because there will be limits on spending for administrative purposes, any underspend will be available to invest in patient care.

The amendments also allow the Secretary of State to set additional limits on total capital or revenue resource use that is attributable to particular matters. That is to comply with the technical limits imposed by the Treasury in matters such as the depreciation of capital assets. Amendments 141 and 142 amend clause 23 to mirror those changes in respect of the financial duties that clinical commissioning groups will be under. The board will be able to set capital and revenue resource limits for each clinical commissioning group, and there will be a duty to stay within those limits.

The board will also be able to set additional limits on capital or revenue resource use, including revenue resource use associated with administrative matters where the Secretary of State imposes such limits on the board. Amendments 107, 124, 137 and 147 make consequential changes to reflect the new clause numbering.

The hon. Member for Oldham East and Saddleworth asked whether allocations to clinical commissioning groups will continue to be weighted for deprivation. It is for the commissioning board to decide the most efficient way to allocate resources to clinical commissioning groups. Under proposed new section 13F to clause 19, however, the board will be under a duty to reduce inequalities in access to services and patient outcomes, as well as to deliver any requirement in the mandate from the Secretary of State. It must, therefore, have regard to the prospective burden of disease and disability when determining allocations. Where there is evidence that people from a more deprived background have a greater need for health care services, we would expect allocations to be weighted towards more deprived areas. For those reasons, I urge the Committee to accept the amendments.

Liz Kendall: This is a complicated set of amendments and I will explain what I believe they really seek to achieve. The amendments give the board or, as I will now call it, NHS England more freedom to spend its money how it wants, but they give consortia, or clinical commissioning groups, less freedom to spend the money how they want. They also take away the Secretary of State’s ability to specify for the board and individual consortia how much they may spend on admin costs. That is my understanding of the amendments.

Amendment 85 deletes the current clause in the Bill that gives the Secretary of State the power to tell the board and consortia how much they may spend on administrative costs. Instead, it gives an overall limit, which gives the board the power to shift money around, including resources for admin costs.

A pattern is emerging. The commissioning board, or NHS England, will end up being a super-quango that can spend as much money as it wants on admin costs with far greater power over clinical commissioning groups. I think that GPs and others who were enthusiastic about the Government’s plans will see, step by step in the post-pause Bill, their power and influence taken away by the board in ever more centralised control.

Whatever the Minister says in his description of the financial changes, they are not technical amendments; they are amendments that will shape and drive how the NHS is run, giving NHS England greater control, commissioning groups less control and, overall, taxpayers less control over how admin costs are spent.

6.36 pm

Sitting suspended for Divisions in the House.

7.6 pm

On resuming—

The Chair: I call Liz Kendall to continue addressing the Committee on Government amendment 84.

Liz Kendall: Thank you, Mr McCrea, but I had finished the point I was making before the Committee was suspended.

Mr Burns: I can be extremely brief. The hon. Lady raised two issues. One of them was the funding of the administrative costs of the commissioning board and the CCGs. We have always made it plain that a global figure will be allocated by the commissioning board, for its own use and for the CCGs. That has not changed. We have also made it clear that the figure we have in mind for the CCGs for their administrative costs will be somewhere between £25 and £35 per patient, and we are looking at the experience of the current pathfinders to determine the exact amount. There will be an incentive for the groups to get cost-effective administration because they can use money saved from that in patient care.

Owen Smith: The Minister is saying, then, that any surpluses that derive from saving on administrative costs can be retained by the consortia—the groups—and invested in clinical or patient care. Does the money have to be invested in that way, or could the consortia choose to spend the retained surplus in other ways?
Mr Burns: First, I would not use the word “surplus”—I would do it the other way around. If in a given year there is money that a group does not spend on administration because it has been particularly efficient and lean, that money can be reinvested in patient care.

Owen Smith: Will the Minister give way?

Mr Burns: No. I think that I answered the hon. Gentleman’s question clearly—

Owen Smith: No, you did not.

Mr Burns: The hon. Gentleman can look at the record tomorrow.

The hon. Lady also mentioned that she interpreted this group of amendments as meaning more freedom for the board and less for the CCGs, but I am afraid that I do not share that analysis of the situation. We have always said that the board will be responsible for accounting for NHS resources, and the chief executive will be the accounting officer. The amendments do not give the board any more substantial powers to set spending limits than those that were in the clause previously agreed by the Committee. There are additional powers to set technical limits on matters such as the depreciation of assets, but only when such limits are imposed on the Department by the Treasury and fed through to the board and the CCGs.

Owen Smith: It is a great pleasure to serve under your chairmanship, Dr McCrea, albeit late in the day. I want to make two brief points, on which I hope the Minister will at some point be able to provide clarification. One relates to his statement that there will now be a global sum of money. Does that change the previous position, in which a distinction was made in the Bill between the moneys that would be made available to the CCGs and to the board? Is it now one global pot of money, which, as my hon. Friend the Member for Leicester West has said, gives the board greater leeway?

My second question relates to the point that I raised a moment ago. The Minister did not precisely repeat what he said. He said that the money could be available to reinvest in patient care, or would be available to reinvest in patient care, neither of which answered my question. Could the money be invested in something else, such as the salaries of the people on the commissioning board, or the purchase of a new fleet of cars?

Mr Burns: I made it quite clear, and I really do not want to drag this out. If the CCGs were particularly efficient and had some money left over from their administration budget, they would be able to use it on investing in patient care. They could not spend the money on increasing their salaries, having a bonus or buying a fleet of cars.

On underspends, I have been consistent and the matter is quite straightforward. There will be an administrative budget for the administrative purposes of the national commissioning board. The board will distribute money when we have determined what the CCGs’ funding will be; it will be somewhere between £25 and £35 per patient, which will be distributed to the CCGs to spend. That comes out of a global administrative budget, which seems to me quite straightforward. I cannot see any problem with that.

Amendment 84 agreed to.

Amendment 86, in clause 20, page 23, leave out lines 33 and 34.
Amendment 87, in clause 20, page 23, leave out lines 35 to 37.
Amendment 88, in clause 20, page 23, line 38, leave out from beginning to end of line 5 on page 24.
Amendment 89, in clause 20, page 24, leave out lines 6 to 15 and insert—

223D Financial duties of the Board: expenditure

(1) The Board must ensure that total health expenditure in respect of each financial year does not exceed the aggregate of—

(a) the amount allotted to the Board for that year under section 223B,
(b) any sums received by the Board or commissioning consortia in that year under any provision of this Act (other than sums received by the Board under section 223B or by commissioning consortia under section 223H), and
(c) any sums received by the Board or commissioning consortia in that year otherwise than under this Act for the purpose of enabling it or them to defray such expenditure.

(1A) In this section, “total health expenditure”, in relation to a financial year, means—

(a) expenditure which is attributable to the performance by the Board of its functions in that year, other than sums paid by it under section 223H, and
(b) expenditure which is attributable to the performance by commissioning consortia of their functions in that year.

Amendment 90, in clause 20, page 24, line 17, after ‘the Board’, insert ‘or a commissioning consortium which is’.

Amendment 91, in clause 20, page 24, line 19, leave out ‘expenditure within subsection (1)’ and insert ‘part of total health expenditure’.

Amendment 92, in clause 20, page 24, line 21, leave out ‘under section 223B’ and insert ‘or a commissioning consortium under section 223B or (as the case may be) 223H’.

Amendment 93, in clause 20, page 24, line 23, leave out ‘the expenditure of the Board’ and insert ‘total health expenditure’.

Amendment 94, in clause 20, page 24, line 28, leave out from beginning to end of line 12 on page 25 and insert—

223DA Financial duties of the Board: controls on total resource use

(1) In this Chapter—

“total capital resource use”, in relation to a financial year, means the use of capital resources in that year by the Board and commissioning consortia (taken together);

“total revenue resource use”, in relation to a financial year, means the use of revenue resources in that year by the Board and commissioning consortia (taken together).

(2) The Board must ensure that total capital resource use in a financial year does not exceed the amount specified by the Secretary of State.
(3) The Board must ensure that total revenue resource use in a financial year does not exceed the amount specified by the Secretary of State.

(6) The Secretary of State may give directions, in relation to a financial year, specifying descriptions of resources which must, or must not, be treated as capital resources or revenue resources for the purposes of this Chapter.

(7) The Secretary of State may give directions, in relation to a financial year, specifying uses of capital resources or revenue resources which must not be taken into account for the purposes of this Chapter.

(8) The Secretary of State may give directions, in relation to a financial year, specifying uses of capital resources or revenue resources which must be taken into account for the purposes of this section.

(9) The amount specified for the purposes of subsection (2) or (3) may be varied only if—

(a) the Board agrees to the change, or

(b) the Secretary of State considers that there are exceptional circumstances which make the variation necessary.

(10) Any reference in this Chapter to the use of capital resources or revenue resources is a reference to their expenditure, consumption or reduction in value.

223DB Financial duties of the Board: additional controls on resource use

'(1) The Secretary of State may direct the Board to ensure that total capital resource use in a financial year which is attributable to matters specified in the direction does not exceed an amount so specified.

(2) The Secretary of State may direct the Board to ensure that total revenue resource use in a financial year which is attributable to matters specified in the direction does not exceed an amount so specified.

(3) The Secretary of State may direct the Board to ensure —

(a) that total revenue resource use in a financial year which is attributable to such prescribed matters relating to administration as are specified in the direction does not exceed an amount so specified;

(b) that the Board’s use of revenue resources in a financial year which is attributable to such prescribed matters relating to administration as are specified in the direction does not exceed an amount so specified.

(4) The Secretary of State may give directions, in relation to a financial year, specifying uses of capital resources or revenue resources which must, or must not, be taken into account for the purposes of subsection (1) or (as the case may be) subsection (2) or (3).

(5) The Secretary of State may not give a direction under subsection (1) or (2) unless the direction is for the purpose of complying with a limit imposed by the Treasury.‘.—[Mr Simon Burns.]

Clause 20, as amended, ordered to stand part of the Bill.

Clause 21

COMMISSIONING CONSORTIA: ESTABLISHMENT ETC.

Mr Burns: I beg to move amendment 95, in clause 21, page 27, line 18, leave out ‘and’ and insert—

'(a) that the applicants have made appropriate arrangements to ensure that the consortium will have a governing body which satisfies any requirements imposed by or under this Act and is otherwise appropriate, and'.

The Chair: With this it will be convenient to discuss amendment 5, in clause 21, page 27, line 18, at end insert—

‘(ca) that the constitution contains provision for an executive board of the consortium, which must—

(i) meet in public,

(ii) publish agendas and minutes of its meetings,

(iii) include appropriate representation of a range of clinicians among its membership,

(iv) include appropriate local democratic representation among its membership, and

(v) include appropriate patient representation among its membership,

(eb) that the area specified by the constitution contains a sufficiently large population for the consortium to be able to commission health services for that population effectively’.)

Government amendments 96 to 105.

Amendment 52, in schedule 2, page 256, line 14, after ‘determine’, insert—

‘having due regard to the NHS pay scales agreed following recommendations by the NHS Pay Review Body and the Doctors and Dentists Pay Review Body, or any successor bodies.’

Amendment 53, in schedule 2, page 256, line 16, after ‘determine’, insert—

‘having due regard to agreements made by the NHS Staff Council’.

Government amendment 106.

Mr Burns: I will speed through these amendments quickly, because we are pressed for time. They return to territory that is familiar from the previous Committee. We discussed the concerns of right hon. and hon. Members about the need for appropriate governance arrangements for clinical commissioning groups, and the need to ensure that that was balanced by not imposing micro-management on the commissioners. Our previous discussions of amendments that were proposed by the Opposition to require consortia to have a governing body resulted in the amendments being withdrawn, which is a clear sign that getting prescriptions about governance arrangements right is a tricky business.

Amendments 52 and 53 were discussed in the 13th session of the first Commons Public Bill Committee, and were accordingly voted against. We have always regarded it as essential that statutory requirements that are placed on clinical commissioning groups do not stifle local organisational development or inhibit the potential of those groups to develop arrangements locally to meet the needs of their patients and their populations. The programme of local pathfinders is the practical result, as groups of GPs come together to develop emerging CCGs and to explore key issues with PCTs.

It is for those reasons that the Government have not hitherto proposed requiring a particular model of governance for CCGs. The Bill as currently drafted and scrutinised has many requirements relating to CCG governance. Developing commissioning groups would need to take account of these, as would the NHS commissioning board as part of its scrutiny of a clinical commissioning group’s competence to deliver its statutory functions, before granting authorisation. Since then, both the Health Committee and the Future Forum have made recommendations pertaining to the need to ensure robust governance in CCGs, reflecting the concerns raised by stakeholders.
7.15 pm

There were similarities between the recommendations, which might be divided into three categories: a concern that CCGs should conform to the highest standards of governance; that the governance arrangements should ensure absolute transparency and probity in the way in which CCGs conduct their business, particularly in reaching the key commissioning decisions; and the need to ensure that lay members and professionals such as nurses or hospital doctors are represented in the governing body of a GP-led CCG.

We fully support Future Forum’s recommendation that “commissioners of NHS services should have a governing body that holds meetings in public, with independent members, to provide independent challenge, including ensuring that consortia fulfil their duty for genuine patient and public involvement.”

We do not need to debate in detail the principles on which we are in agreement. Clearly, we all want clinical commissioning groups to attain the highest standards of public sector governance, particularly ensuring probity and managing any potential conflicts of interest, engaging meaningfully with patients, the public and other health professionals locally as well as with democratic representatives and always acting transparently.

In our response to the Future Forum, we indicated our willingness to make the necessary legislative changes to deliver them. The necessary amendments will introduce a more robust and comprehensive framework for CCGs than the proposals of Opposition Members. The Government amendments deliver some duties similar to those in Opposition amendment 5, but they reflect more effectively what is required to provide the safeguards needed to ensure that CCGs attain those high standards of governance. We accept the need for a governing body within the CCGs with responsibility for ensuring good governance, and amendments 95, 98, 100 to 101 and 104 to 106 provide for that.

Unlike amendment 5, our amendments provide a high-level function of the governing body to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently, economically and in compliance with principles of good governance. That, of course, embraces such standards as the Nolan principles, which the Future Forum recommended. The Future Forum recommendation that “Transparency and openness should run throughout the health and wellbeing system, particularly in relation to how public money is spent” is one with which we entirely concur.

Our amendments 96, 97 and 104 require that CCGs meet in public, except when discussing confidential issues. Commissioning groups will also be required to publish their constitutions and to give the commissioning board a power to publish guidance on the publication of these constitutions. The constitution of a CCG is already required to set out arrangements to be followed by the group in reaching decisions. Government amendment 102 adds that each CCG should set out specific arrangements in the constitution for ensuring transparency on the decisions of the consortium and the manner in which those decisions are made. These arrangements might include building on the proposals for a governing body with lay membership, with the potential to scrutinise commissioning decisions and provide what the NHS Future Forum termed “independent challenge”; developing their relationship with local stakeholders and democratically elected representatives in the health and well-being board, with whom the CCG must consult on their commissioning plans; or developing the relationship with patients and their representatives.

Clearly, there are many ways in which this duty might be fulfilled, and we do not want to be too prescriptive and risk preventing innovative and imaginative approaches, as clinicians locally develop the groups that best enable them to fulfil their statutory functions. As these arrangements will be set out in the constitution, they will be considered by the NHS commissioning board as part of its scrutiny of a CCG’s competence to deliver its statutory functions before granting authorisation and its ongoing oversight of the competence of CCGs. In addition, the public will now also be able to scrutinise the document when it is published. These amendments help to ensure quality outcomes by putting in place safeguards and allowing the public a clear view of how the business of commissioning is undertaken, and how they can be major participants in the crucial decisions that affect their health and well-being.

The governing body will also have the function of determining the remuneration of commissioning group employees and others providing services to it, and it must have a remuneration committee. This committee will make recommendations to the commissioning board’s governing body on remuneration, fees and allowances with the scope for further functions to be assigned to it as set out in the CCG’s constitution or in regulations.

New section 14JA(7), which amendment 98 inserts, will enable regulations to require governing bodies to publish prescribed information relating to the determination of remuneration, fees and allowances payable to the employees of the clinical commissioning group or others providing services to it. Under new section 14JA(8), the board may publish guidance for governing bodies on the exercise of these functions. I hope that that reassures Opposition Members that amendments 52 and 53 are not necessary and are over-prescriptive.

In responding to recommendations of the Future Forum, we have taken great care to ensure that the statutory duties on CCGs are wholly proportionate. We also recognise the need for ensuring, via the flexibility of regulations, that CCGs are fully supported in establishing these governing bodies. Regulations may make provision for the qualification or disqualification of members, as happens currently for PCT boards, and for the way in which members are to be appointed, clarifying eligibility and tenure of members.

By describing our amendments in some detail, I hope that I have reassured Opposition Members that their amendments are no longer necessary, where they address the same issues. However, there are some points raised by amendment 5 that I have not yet addressed, and I would like to take the opportunity to do so now.

Amendment 5 would put in the Bill requirements for appropriate representation. We support the principle of involving patients and non-GP clinicians in the work of the CCG and involving them as members of a governing body. However, requiring in the Bill that the membership should include appropriate representation of a range of clinicians is imprecise and might be satisfied by clinicians entirely associated with general practice, such as a practice nurse, GP or a GP with a special interest. It would be for the commissioning board to satisfy itself on the
appropriate representation. Our proposed amendment would allow us, through permissive regulation-making powers, to specify the types of clinicians who must be represented. We have made a commitment in our response to the Future Forum that this should be a minimum of a doctor working in secondary care and a registered nurse. The regulations will ensure that this commitment is reflected in legislation.

Mr Barron: There are some issues around a doctor who works in secondary care. Might we see a situation in which a retired doctor could be appointed to a commissioning group, or would it have to be a working doctor who is up to speed on modern medicine?

Mr Burns: I hope that this reassures the right hon. Gentleman, because it could be a retired doctor, if they fit the criteria.

In a briefing sent to the Committee yesterday, the Royal College of Nursing welcomed this intention. It explained that nurses have a pivotal role in being able to stand back and view the whole care pathway, taking a holistic perspective to look above the day-to-day clinical issues and effectively commission services.

The president of the Royal College of Physicians, Sir Richard Thompson, has also said that the RCP welcomes the Government's commitment that hospital doctors will be on the board of commissioning groups. We believe that such a move will benefit patient care by bringing together clinical colleagues in commissioning decisions.

With regard to lay membership, we intend to go beyond the proposal tabled by the Opposition. We will require through regulations not simply a patient representative but a minimum of two lay members—one who will champion the interests and rights of patients and one with the appropriate expertise to take an informed and independent view of the performance of the CCG against its financial responsibilities. The latter will act in the role of a non-executive director with responsibility for audit with a dedicated sub-committee of the governing body. As we heard in the evidence sessions, there is wide support for that, especially from patient groups such as National Voices, Rethink Mental Illness and Macmillan Cancer Support.

In response to the requirement for local democratic representation, I remind the Committee that health and well-being boards, with their functions of collaborating with CCGs on joint health and well-being strategies and their proposed role in scrutinising CCG annual commissioning plans, will provide a powerful local hub for local democratic involvement in commissioning, which is clearly set out in the Bill.

Finally, amendment 5 seeks to make specific provision in the Bill for the NHS commissioning board to ensure, when it considers an application from a prospective CCG, that the area that the group covers contains a sufficiently large population. We all agree that it is essential for CCGs to be able to commission to meet the needs of the population for whom they have responsibility. However, the amendment is unnecessary, because under clause 21 the board must be satisfied that the area specified in the commissioning group's constitution is appropriate, and that the CCG has made appropriate arrangements to ensure that it can discharge its statutory duties.

Although amendment 5 is on the right track, it would respond neither practically nor proportionately to concerns about CCGs and good governance. For those reasons, I urge Opposition Members not to press the amendments to a vote. Instead, the Committee should support Government amendments 95 to 106.

Liz Kendall: This is an unbelievable U-turn by the Government. We argued strongly that there was an astonishing omission from the Government's first Bill relating to people in clinical commissioning consortia. Such people were to be responsible for £80 billion—now it is to be £60 billion; I do not know when or how that was changed. There was no requirement to have any kind of effective board or governing body, and there was an astonishing lack of concern about public money. For a Government who claim to be concerned about spending public money, it was an astonishing omission. It is Opposition Members who are concerned about effective spending of taxpayers' money, and I am glad that the Government now agree that we were right all along.

In addition, when the Bill was first in Committee, we debated an Opposition amendment. Government Members, particularly the hon. Member for Southport, who is not here, sadly, to represent the Liberal Democrats, who are very concerned about democratic accountability, said that our amendment was too prescriptive, referring to a series of clinicians, health professionals, lay members and democratic representatives. Now, however, lo and behold, the Government have completely changed their mind and included the changes.

I withdrew that amendment, Dr McCrea—you appeared to enjoy that part of the debate—because I wanted to consider whether it was over-prescriptive, but the Government have now tabled an amendment that goes into minute detail in micro-managing the NHS. The regulations will give the board the ability to determine the minimum and maximum number of people in the CCGs; it will be able to determine the frequency of their meetings; and it will even be able to determine the names of CCGs and, according to the Government's briefing on the amendment, insert “NHS” before such names. Perhaps NHS Leicester City, my old primary care trust, will become NHS Leicester City again. It is astonishing.

The Minister now accuses us of being too imprecise in amendment 5, because we want “a range of clinicians” to be on the board. That would give clinical commissioning groups the ability to specify not only doctors or nurses, but other professions allied to medicine, such as dentists or pharmacists, if they see fit.

It is astonishing that we are the ones who, in amendment 5, are specifying broadly the different groups who should be included in the group without going into excessive detail and micro-management. I will press the amendment to a vote, because the Government have failed to give us enough time to scrutinise the legislation.

We include the requirement for commissioning consortia to cover a sufficiently large population, because, as hon. Members should remember, we are worried that if groups are too small, and they have one or two expensive
patients, particularly at the end of the year, they would go bust. Hon. Members should also remember that the Nuffield Trust has been commissioned by the Government to model how big clinical commissioning groups should be, so that they do not go bust. We are trying to do the Government’s work for them in this area.

7.30 pm

Mr Barron: I would like to put on the record my congratulations to my Front-Bench colleagues on leading the Government in this area. Does my hon. Friend agree that the new team sheet looks suspiciously like a team sheet for a pulmonary care trust?

Liz Kendall: My right hon. Friend is right. That is exactly what will happen in my constituency. We have had a massive reorganisation of NHS Leicester City involving GPs, lay representatives and so on, whom we said at the beginning of the Bill should be included.

We welcome the requirement, as we argued at our previous sitting, that the governing bodies—the clinical commissioning groups—should meet in public, but the Government have added a line about excluding discussion of confidential matters. I am keen for the Minister to say exactly what sort of confidential matters—

Mr Burns: Oh, God!

Liz Kendall: Yet again, the Minister has said, “Oh, God.” I am sorry, but I am asking questions about his Bill. That is my job, and I hope that he will respond.

I want to put on the record the fact that members of the NHS Future Forum will be hugely disappointed that the Government have completely ignored its recommendation that all providers of services to NHS patients should also meet in public and publish their agendas. The Government have not responded to that real concern of the Future Forum to make sure that anyone who provides services to NHS patients should be required to publish their agenda and meet in public, to ensure the openness and transparency of which the Government are supposedly great champions.

I have some questions for the Minister about concerns raised by the Nuffield Trust and the NHS Confederation in their briefings on the re-committed Bill. First, the amendments now say that the doctor and nurse must be from outside the area of the clinical commissioning group to avoid conflict of interest. How practical is that? If GPs can be on the board, and they deliver services in the area, why cannot nurses and doctors? That is precisely what commissioning is. If the Minister does not understand that, he will not enable the changes that the NHS needs to make to deliver efficiency savings and improve patient care.

On funding, what money will be made available to provide the locum cover for clinical representatives or to pay lay representatives? Where is the costing for that? How will that money be found?

I want to make a serious point about safeguarding. I tried to raise the issue in the evidence session, and it is something my local council is concerned about. I have no idea who will be responsible for appointing the person responsible for safeguarding children in different services in the NHS. Many local councils are concerned that GPs have not often been as fully engaged in the issue as they should have been, but they will now be responsible for it. Will the Minister clearly say who will be responsible for defining safeguarding leads throughout the NHS?

Fiona O’Donnell: I want to reinforce that point, and I am so pleased that my hon. Friend has raised it. Successive inquiries into tragedies where children have been abused, or, even worse, have died, have shown that the root of the problem is often where communication has broken down between the people involved in the care of that child and the family. We cannot have a backward step here. We need clarification, so that children can continue to be safeguarded.

Liz Kendall: I thank my hon. Friend. This issue is something I am genuinely concerned about. The Bill is completely unclear about where that responsibility should lie. I suggest to the Government that the responsibility for deciding who will be the main person responsible for safeguarding within the NHS should move to local councils as part of their new responsibilities on health, because they may have more knowledge and understanding.

We want to put our remaining amendments to the vote. Amendment 51 states that the constitution of the clinical commissioning group must make clear provision for dealing with any other personal and prejudicial interests of members or employees.

The Chair: Order. I should tell the hon. Lady that amendment 51 is not in this group.

Liz Kendall: Sorry, Dr McCrea. I will move on to amendments 52 and 53. Amendment 52 would require consortia or their governing bodies to ensure that they have regard to “NHS pay scales agreed following recommendations by the NHS Pay Review Body and the Doctors and Dentists Pay Review Body, or any such successor bodies”.

Many staff are concerned that the Bill will not protect the current national agreements, on which the previous Government worked extremely hard in the “Agenda for Change”, to ensure fair pay and that staff can progress in their careers.

Amendment 53 would require consortia to have regard to “agreements made by the NHS Staff Council.”
The NHS staff council and the social partnership forum have been important mechanisms for ensuring that the views of staff and their representatives have been heard. That is not enshrined in the Bill at the moment. Staff are concerned that, with the changes to the Bill, agreements made nationally, including on pay and remuneration, will not be honoured. That is the reason for the amendment, which we will press to a Division.

Jim Shannon (Strangford) (DUP): I apologise for not being here earlier on, Dr McCrea. I would just like to ask the Minister a question. We have all had correspondence with the National Children's Bureau. There is a governing body called Every Disabled Child Matters, which consists of four groups. One of those groups is Mencap, which is the organisation that contacted me. It is, by and large, comparatively supportive of the Government's proposals, but it has a question I would like to put to the Minister.

The question relates to children with complex needs and to those who are disabled. I do not want to be disrespectful to GPs, but nobody knows everything. GPs have a lot of knowledge but do not necessarily know everything they need to know. Sometimes help is needed for disabled children, or for children with complex needs. If that help is needed, we need to ensure that GPs are supportive and are able to offer that. Will the Minister provide assurances that the regulations will ensure that the governing body of each commissioning consortium must include a clinician with experience of providing health care for children with complex needs? That is the question Mencap asked me to put to the Committee. In his response, can the Minister give conclusive evidence and support for the point of view expressed by Mencap?

Fiona O'Donnell: I want to touch on a couple of points. The first concerns the openness of meetings of commissioning groups. We already have legislation in place: the Public Bodies (Admission to Meetings) Act 1960, which presently applies to PCTs and strategic health authorities. I see no reason why that should not apply in this case. That would remove any suspicion. We keep talking about trust on this side of the Committee, and it is so important.

On the amendment relating to pay and negotiations, and the terms and conditions of staff employed by the commission, I know the Government are very concerned about bad headlines in the Daily Mail. There is real potential here for that to happen. I can just see stories saying, “GP gets new Jag off the back of underpaid nurse.”

Dr Poulter: I am delighted that the hon. Lady is taking an interest in the pay of front-line staff. She will be aware that her Government allowed management to gain year-on-year pay rises of 7%, whereas front-line staff were given a pay rise of only 1.8%. How does she reconcile that with the comments she has just made?

Fiona O'Donnell: This Government have an admirable aim to do better than previous ones, but I have to say that in the case of this Bill, they are failing miserably. I ask the Minister to reassure me, given the concerns raised in the House yesterday during the Finance Bill debate, that all these workers will continue to be classed as public service workers. For example, on the question of a £250 tax break for low-paid public sector workers, I want an assurance that all workers employed will still be categorised as public sector workers.

7.45 pm

I cannot praise enough the contributions from my hon. Friend the Member for Leicester West. I have seen Government Members’ jaws hitting the table, thinking that she is making a meal of the Bill and the amendments, but the that it is the Government who have made this process incredibly complex and difficult. It has fallen to my hon. Friend and me to explain to those hon. Members exactly what the Bill and their amendments mean.

Amendment 95 agreed to.

Amendment proposed: 5, in clause 21, page 27, line 18, at end insert—

‘(ea) that the constitution contains provision for an executive board of the consortium, which must—

(i) meet in public,
(ii) publish agendas and minutes of its meetings,
(iii) include appropriate representation of a range of clinicians among its membership,
(iv) include appropriate local democratic representation among its membership, and
(v) include appropriate patient representation among its membership,

(eb) that the area specified by the constitution contains a sufficiently large population for the consortium to be able to commission health services for that population effectively.’.—[Liz Kendall.]

Question put. That the amendment be made.

The Committee proceeded to a Division.

Jim Shannon: On a point of order, Dr McCrea. For clarification, those of us who asked questions were hoping for a reply from the Minister. Does he intend to reply now, or will he write to us.

The Chair: We are in the middle of a Division, so I will not answer questions now.

The Committee having divided: Ayes 10, Noes 13.

Division No. 11]

AYES

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

NOES

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

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

Question accordingly negatived.
Jim Shannon: On a point of order, Dr McCrea. I am sorry to be so pushy on this matter, but we asked some questions and would like clarification. Will the Minister respond verbally now or write to us?

The Chair: I have already stated that the Minister can take the opportunity to do so during clause stand part debate, because there was an oversight. However, I am sure that he will be happy to put in writing the answers to any questions not answered in Committee.

Amendments made: 96, in clause 21, page 29, line 28, at end insert—

14IA Publication of constitution of consortia

(1) A commissioning consortium must publish its constitution.

(2) If the constitution of a commissioning consortium is varied under section 14E or 14F, the consortium must publish the constitution as so varied.'.

Amendment 97, in clause 21, page 29, line 35, at end insert—

'(1) the publication of the constitutions of commissioning consortia under section 14IA.'.

Amendment 98, in clause 21, page 29, line 35, at end insert—

Governing bodies of consortia

14JA Governing bodies of commissioning consortia

'(1) A commissioning consortium must have a governing body.

(2) The main function of the governing body is to ensure that the consortium has made appropriate arrangements for ensuring that it complies with—

(a) its obligations under section 14K, and

(b) such generally accepted principles of good governance as are relevant to it.

(3) The governing body also has—

(a) the function of determining the remuneration, fees and allowances payable to the employees of the consortium or to other persons providing services to it, and

(b) such other functions connected with the exercise of its main function as may be specified in the consortium's constitution or by regulations.

(4) Only the following may be members of the governing body—

(a) a member of the consortium who is an individual;

(b) an individual appointed by virtue of regulations under section 14JC(2); and

(c) an individual of a description specified in the constitution of the consortium.

(5) A commissioning consortium may pay members of the governing body such remuneration and allowances as it considers appropriate.

(6) Regulations may make provision requiring a commissioning consortium to obtain the approval of its governing body before exercising any functions specified in the regulations.

(7) Regulations may make provision requiring governing bodies of commissioning consortia to publish, in accordance with the regulations, prescribed information relating to determinations made under subsection (3)(a).

(8) The Board may publish guidance for governing bodies on the exercise of their function under subsection (3)(a).

14JB Audit and remuneration committees of governing bodies

'(1) The governing body of a commissioning consortium must have an audit committee and a remuneration committee.

(2) The audit committee has—

(a) such functions in relation to the financial duties of the consortium as the governing body considers appropriate for the purpose of assisting it in discharging its function under section 14JA(2), and

(b) such other functions connected with the governing body’s function under section 14JA(2) as may be specified in the consortium's constitution or by regulations.

(3) The remuneration committee has—

(a) the function of making recommendations to the governing body as to the discharge of its function under section 14JA(3)(a), and

(b) such other functions connected with the governing body’s function under section 14JA(2) as may be specified in the consortium's constitution or by regulations.

14JC Regulations as to governing bodies of commissioning consortia

'(1) Regulations may make provision specifying the minimum number of members of governing bodies of commissioning consortia.

(2) Regulations may—

(a) provide that the members of governing bodies must include the accountable officer of the consortium;

(b) provide that the members of governing bodies, or their audit or remuneration committees, must include—

(i) individuals who are health care professionals of a prescribed description;

(ii) individuals who are lay persons;

(iii) individuals of any other description which is prescribed;

(c) in relation to any description of individuals mentioned in regulations by virtue of paragraph (b), specify—

(i) the minimum number of individuals of that description who must be appointed;

(ii) the maximum number of such individuals who may be appointed;

(d) provide that the descriptions specified for the purposes of section 14JA(4)(c) may not include prescribed descriptions.

(3) Regulations may make provision as to—

(a) qualification and disqualification for membership of governing bodies or their audit or remuneration committees;

(b) how members are to be appointed;

(c) the tenure of members (including the circumstances in which a member ceases to hold office or may be removed or suspended from office);

(d) eligibility for re-appointment.

(4) Regulations may make provision for the appointment of chairs and deputy chairs of governing bodies or their audit or remuneration committees, including provision as to—

(a) qualification and disqualification for appointment;

(b) tenure of office (including the circumstances in which the chair or deputy chair ceases to hold office or may be removed or suspended from office);

(c) eligibility for re-appointment.

(5) Regulations may—

(a) make provision as to the matters which must be included in the constitutions of commissioning consortia under paragraph 5B of Schedule 1A;

(b) make such other provision about the procedure of governing bodies or their audit or remuneration committees as the Secretary of State considers appropriate, including provision about the frequency of meetings.

(6) In this section—
Trusts will transfer to the clinical commissioning groups which would be responsible. The functions of primary care must be maintained and we will use the regulations only to set the core approach. We believe that it will work.

The hon. Lady asks me to speculate again, but I am afraid that, at this time of the evening, I will not do so. I will, however, continue to answer some more questions.

The hon. Lady also said that the board has wide-ranging regulation-making powers, but it is not the board that has the regulation-making powers. The Secretary of State makes regulations in agreement with Parliament, and we will use the regulations only to set the core requirements for governing bodies. Anything further is for local determination, based on organisational needs.

Liz Kendall: What I asked was, if doctors, nurses and clinicians on the boards of clinical commissioning groups will not be giving advice on major changes to local services—which is what the Minister previously said the clinical senates will be doing—what on earth will they be doing? That is what commissioning is.

Mr Burns: Let me classify and explain what the two groups will do. A governing body is focused on governance issues, whereas clinical advice from senates is focused on bringing together clinicians from different settings to discuss how to provide joined-up care across an area. I hope that that satisfies the hon. Lady.

The hon. Member for Strangford asked whether a CCG’s governing body will include secondary care doctors with experience of caring for children with complex needs. We will not make that a requirement, because it would be too prescriptive, but I take the point, which is important. We want to ensure that CCGs have access to expertise through, for example, the senate and the networks. That is the way in which we want to input the expertise, help and guidance needed to achieve those aims.

Graham M. Morris: Will the CCGs have a right to veto any recommendations from the clinical senates, or will they be duty bound to take their advice on clinical issues?

Mr Burns: No, they will not, because the system will not work like that. The senates are there to input advice. By definition, advice can be taken, rejected, or partly taken. A senate is an advisory body that will input advice based on its expertise.

Another point was made about the cost of the governing bodies of CCGs. The hon. Member for Leicester West will groan at this, but we are awaiting the updated impact assessment, which will reflect the additional costs, if any, of the amendment.

The hon. Lady mentioned conflicts of interest and asked why a secondary care doctor in the same area as a CCG would not be able to participate in its proceedings. The answer, as we have said all along, is that we are seeking to ensure that there are no conflicts of interest with such individuals, which is why secondary care doctors should come from outside the immediate area of the CCG, so as not to arouse the suspicion, the allegation or the reality of a conflict of interest. We have introduced that provision with the best of intentions and we believe that it will work.

The hon. Lady also said that the board has wide-ranging regulation-making powers, but it is not the board that has the regulation-making powers. The Secretary of State makes regulations in agreement with Parliament, and we will use the regulations only to set the core requirements for governing bodies. Anything further is for local determination, based on organisational needs.

[Interruption.] That is the right way forward, whatever the hon. Lady. Lady is chirping from the sidelines.
The hon. Lady also suggested—that is now one of her old chestnuts—that the provision represents gross micro-management. Nothing could be further from the truth. It is not micro-management to set down some basic parameters for a governing body. We do it for PCTs and other public bodies and it is a proportionate approach for bodies that are stewards of billions of pounds of public money. If we were not taking such a reasonable and proportionate approach, the hon. Lady, given the mood she is in, would be criticising us from the other side of the argument. The hon. Lady’s approach to debating leaves me in a no-win situation.

The regulations will allow us to set out processes to be observed by CCGs when making arrangements for their governing bodies and their committees. The regulations are a safeguard to prevent inadequate arrangements that fail to ensure good governance, which I do not think is the case, I will ensure that we write to hon. Members.

As we are coming so near to the knife, I will conclude my comments. If there are any questions that I have not answered, which I do not think is the case, I will ensure that we write to hon. Members.

Question put and agreed to.

Clause 21, as amended, accordingly ordered to stand part of the Bill.

Schedule 2

Commissioning consortia

Amendments made: 99, in schedule 2, page 255, line 11, at end insert—

'( ) The name of the consortium must comply with such requirements as may be prescribed.'.

Amendment 100, in schedule 2, page 255, line 14, leave out ‘remuneration and the other’.

Amendment 101, in schedule 2, page 255, line 24, leave out ‘or’ and insert—

( ) its governing body, or’.

Amendment 102, in schedule 2, page 255, line 30, at end insert—

'( ) The constitution must also specify the arrangements made by the commissioning consortium for securing that there is transparency about the decisions of the consortium and the manner in which they are made.’.—[Mr Simon Burns.]

8 pm

Proceedings interrupted (Programme Order, 28 June).

The Chairman then put forthwith the Questions necessary for the disposal of the business to be concluded at that time (Standing Order No. 83D).


Amendment 104, in schedule 2, page 255, line 33, at end insert—

‘Governing bodies of consortia

5A (1) The constitution must specify the arrangements made by the commissioning consortium for the discharge of the functions of its governing body.

(2) The arrangements—

(a) must include provision for the appointment of the audit committee and remuneration committee of the governing body, and

(b) may include provision for the appointment of other committees or sub-committees of the governing body.

(3) Arrangements under sub-paragraph (2)(a) may include provision for the audit committee to include individuals who are not members of the governing body.

(4) Arrangements under sub-paragraph (2)(b) may include provision for a committee or sub-committee to include individuals who are not members of the governing body but are—

(a) members of the consortium, or

(b) individuals of a description specified in the constitution.

(5) The consortium may pay travel or other allowances to members of any committee or sub-committee of the governing body who are not members of the governing body.

(6) The arrangements may include provision for any functions of the governing body to be exercised on its behalf by—

(a) any committee or sub-committee of the governing body,

(b) a member of the governing body,

(c) a member of the consortium who is an individual (but is not a member of the governing body), or

(d) an individual of a description specified in the constitution.

5B (1) The constitution must specify the procedure to be followed by the governing body in making decisions.

(2) The constitution must, in particular, make provision for dealing with conflicts of interests of members of the governing body.

(3) The constitution must also specify the arrangements made by the commissioning consortium for securing that there is transparency about the decisions of the governing body and the manner in which they are made.

(4) The provision made under sub-paragraph (3) must include provision for meetings of governing bodies to be open to the public, except where the consortium considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting.’.

Amendment 105, in schedule 2, page 256, line 14, leave out ‘it may determine’ and insert

‘its governing body determines under section 14JA(3)(a).’—[Mr Simon Burns.]

Amendment proposed: 52, in schedule 2, page 256, line 14, after ‘determine’, insert

‘having due regard to the NHS pay scales agreed following recommendations by the NHS Pay Review Body and the Doctors and Dentists Pay Review Body, or any successor bodies.’.—[Liz Kendall.]

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 12.

Division No. 12]
Clause 22

COMMISSIONING CONSORTIA: GENERAL DUTIES ETC.

Amendments made: 108, in clause 22, page 30, line 3, at end insert—

14JD Duty to promote NHS Constitution

(1) Each commissioning consortium 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).’.

Amendment 109, in clause 22, page 30, line 28, leave out ‘, promoting patient involvement etc.’.

Amendment 110, in clause 22, page 30, leave out lines 35 to 38.

Amendment 111, in clause 22, page 30, line 40, at end insert—

14NA Duty to promote involvement of each patient

(1) Each commissioning consortium 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) The Board may publish guidance for commissioning consortia on the discharge of their duties under this section.

(3) A commissioning consortium must have regard to any guidance published by the Board under subsection (2).

(4) In this section, “health services” has the same meaning as in section 14N.

14NB Duty as to patient choice

‘(1) Each commissioning consortium 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 14N.’.

Amendment 112, in clause 22, page 31, line 2, leave out from ‘must’ to ‘advice’ in line 3 and insert ‘obtain’. Amendment 113, in clause 22, page 31, line 4, leave out from ‘persons’ to end of line 5 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.’.

Amendment 114, in clause 22, page 31, line 5, at end insert—

‘(2) The Board may publish guidance for commissioning consortia on the discharge of their duties under subsection (1).

(3) A commissioning consortium must have regard to any guidance published by the Board under subsection (2).’.

Amendment 115, in clause 22, page 31, line 5, at end insert—

14OA Duty to promote innovation

(1) Each commissioning consortium must, in the exercise of its functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision).

(2) In this section, “health services” means services provided as part of the health service.’.

Amendment 116, in clause 22, page 31, line 5, at end insert—

14OB Duty in respect of research

Each commissioning consortium must, in the exercise of its functions, have regard to the need to promote—

(a) research on matters relevant to the health service, and
(b) the use in the health service of evidence obtained from research.’.

Amendment 117, in clause 22, page 31, line 5, at end insert—

14OC Duty as to promoting integration

(1) Each commissioning consortium must exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would—

(a) improve the quality of those services (including the outcomes that are achieved from their provision),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

(2) Each commissioning consortium must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related services or social care services where it considers that this would—

Amendment 118, in clause 22, leave out ‘and subsection (2)’. Amendment 119, in clause 22, leave out ‘and subsection (2)’. Amendment 120, in clause 22, leave out ‘and subsection (2)’. …
(a) improve the quality of the health services (including the outcomes that are achieved from the provision of those services),
(b) reduce inequalities between persons with respect to their ability to access those services, or
(c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

(3) In this section—
“health services” means services provided as part of the health service;
“health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;
“social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).”

Amendment 118, in clause 22, page 31, line 18, leave out ‘a significant’ and insert ‘an’.
Amendment 119, in clause 22, page 31, line 24, at end insert—
‘(4) The commissioning consortium must include in its constitution—
(a) a description of the arrangements made by it under subsection (2), and
(b) a statement of the principles which it will follow in implementing those arrangements.’.

Amendment 120, in clause 22, page 32, line 10, at end insert—
‘(5) Arrangements made under this section do not affect the liability of a commissioning consortium for the exercise of any of its functions.’.

Amendment 121, in clause 22, page 32, line 22, at end insert—
‘(6) Arrangements made by virtue of this section do not affect the liability of a commissioning consortium for the exercise of any of its functions.’.

Amendment 122, in clause 22, page 33, line 42, at end insert—
‘(7) Arrangements made under this section do not affect the liability of a commissioning consortium for the exercise of any of its functions.’.

Amendment 123, in clause 22, page 34, line 29, leave out ‘section 14L’ and insert ‘sections 14L and 14P’.

Amendment 124, in clause 22, page 34, line 30, leave out ’223K’ and insert ‘223JA’.

Amendment 125, in clause 22, page 34, line 31, leave out from beginning to end of line 3 on page 35.

Amendment 126, in clause 22, page 35, leave out lines 9 to 22.

Amendment 127, in clause 22, page 35, line 24, leave out ‘subsections (10) to (13)’ and insert
‘this section and sections 14YA and 14YB’.

Amendment 128, in clause 22, page 35, line 27, leave out ‘section’ and insert ‘Chapter’.

Amendment 129, in clause 22, page 35, line 27, after ‘Board’’, insert
’, in relation to a commissioning consortium.’.

Amendment 130, in clause 22, page 35, line 30, at end insert—
14YA Revision of commissioning plans
(1) A commissioning consortium may revise a plan published by it under section 14Y.

14YB Consultation about commissioning plans
(1) This section applies where a commissioning consortium is—
(a) preparing a plan under section 14Y, or
(b) revising a plan under section 14YA in a way which it considers to be significant.
(2) The commissioning consortium must consult individuals for whom it has responsibility for the purposes of section 3.
(3) The consortium must involve each relevant Health and Wellbeing Board in preparing or revising the plan.
(4) The consortium must, in particular—
(a) give each relevant Health and Wellbeing Board a draft of the plan or (as the case may be) the plan as revised, and
(b) consult each such Board on whether the draft takes proper account of each joint health and wellbeing strategy published by it which relates to the period (or any part of the period) to which the plan relates.
(5) Where a Health and Wellbeing Board is consulted under subsection (4)(b), the Health and Wellbeing Board must give the consortium its opinion on the matter mentioned in that subsection.
(6) Where a Health and Wellbeing Board is consulted under subsection (4)(b)—
(a) it may also give the Board its opinion on the matter mentioned in that subsection, and
(b) if it does so, it must give the consortium a copy of its opinion.
(7) If a commissioning consortium revises or further revises a draft after it has been given to each relevant Health and Wellbeing Board under subsection (4), subsections (4) to (6) apply in relation to the revised draft as they apply in relation to the original draft.
(8) A commissioning consortium must include in a plan published under section 14Y(7) or 14YA(2)—
(a) a summary of the views expressed by individuals consulted under subsection (2),
(b) an explanation of how the consortium took account of those views, and
(c) a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the plan under subsection (4).
(9) In this section, “joint health and wellbeing strategy” means a strategy under section 116A of the Local Government and Public Involvement in Health Act 2007 which is prepared and published by a Health and Wellbeing Board by virtue of section 193 of the Health and Social Care Act 2011.”

Amendment 132, in clause 22, page 35, line 30, at end insert—
14YC Opinion of Health and Wellbeing Boards on commissioning plans
(1) A relevant Health and Wellbeing Board—
(a) may give the Board its opinion on whether a plan published by a commissioning consortium under section 14Y(7) or 14YA(2) takes proper account of each joint health and wellbeing strategy published
by the Health and Wellbeing Board which relates to the period (or any part of the period) to which the plan relates, and
(b) if it does so, must give the consortium a copy of its opinion.

(2) In this section, “joint health and wellbeing strategy” has the same meaning as in section 14YB.

Amendment 133, in clause 22, page 35, line 35, after ‘particular’, insert ‘—

(a) ’.

Amendment 134, in clause 22, page 35, line 36, at end insert ‘,’ and—
(b) review the extent to which the consortium has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

(1) In preparing the review required by subsection (2)(b), the consortium must consult each relevant Health and Wellbeing Board.

Amendment 135, in clause 22, page 36, line 9, leave out ‘and’ and insert—

(’)

Amendment 136, in clause 22, page 36, line 9, at end insert—

(’) section 140,

Amendment 137, in clause 22, page 36, line 10, leave out ‘performance’ and insert ‘quality’.

Amendment 138, in clause 22, page 36, line 10, at end insert ‘,’ and

(1) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

Amendment 139, in clause 22, page 36, line 10, at end insert—

(’)

In conducting a performance assessment, the Board must consult each relevant Health and Wellbeing Board as to its views on the consortium’s contribution to the delivery of any joint health and wellbeing strategy to which the consortium was required to have regard under section 116B(1)(b) of that Act of 2007.

Amendment 140, in clause 22, page 40, line 3, at end insert—

“relevant Health and Wellbeing Board”, in relation to a commissioning consortium, has the meaning given by section 14Y(16);—(Mr Simon Burns.)

Clause 22, as amended, ordered to stand part of the Bill.

Clause 23

FINANCIAL ARRANGEMENTS FOR CONSORTIA

Amendments made: 141, in clause 23, page 40, line 41 leave out ‘general’ and insert ‘expenditure’.

Amendment 142, in clause 23, page 41, line 24, leave out from beginning to end of line 10 on page 42 and insert—

(1) For the purposes of this section and section 223JA—

(a) a commissioning consortium’s capital resource use, in relation to a financial year, means the consortium’s use of capital resources in that year, and
(b) a commissioning consortium’s revenue resource use, in relation to a financial year, means the consortium’s use of revenue resources in that year.

(2) A commissioning consortium must ensure that its capital resource use in a financial year does not exceed the amount specified by direction of the Board.

(3) A commissioning consortium must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the Board.

(4) Any directions given in relation to a financial year under subsection (6) of section 223DA apply (in relation to that year) for the purposes of this section as they apply for the purposes of that section.

(5) The Board may by directions make provision for determining to which consortium a use of capital resources or revenue resources is to be attributed for the purposes of this section or section 223JA.

(6) Where the Board gives a direction under subsection (2) or (3), it must notify the Secretary of State.

223JA Financial duties of consortia: additional controls on resource use

‘(1) The Board may direct a commissioning consortium to ensure that its capital resource use in a financial year which is attributable to matters specified in the direction does not exceed an amount so specified.

(2) The Board may direct a commissioning consortium to ensure that its revenue resource use in a financial year which is attributable to matters specified in the direction does not exceed an amount so specified.

(3) The Board may direct a commissioning consortium to ensure that its revenue resource use in a financial year which is attributable to prescribed matters relating to administration does not exceed an amount specified in the direction.

(4) The Board may give directions, in relation to a financial year, specifying uses of capital resources or revenue resources which must, or must not, be taken into account for the purposes of subsection (1) or (as the case may be) subsection (2) or (3).

(5) The Board may not exercise the power conferred by subsection (1) or (2) in relation to particular matters unless the Secretary of State has given a direction in relation to those matters under subsection (1) of section 223DB or (as the case may be) subsection (2) of that section.

(6) The Board may not exercise the power conferred by subsection (3) in relation to prescribed matters relating to administration unless the Secretary of State has given a direction in relation to those matters under subsection (3)(a) of section 223DB.

Amendment 143, in clause 23, page 42, line 11, leave out ‘performance’ and insert ‘quality’.

Amendment 144, in clause 23, page 42, line 13, leave out from ‘consortium’ to end of line 15.

Amendment 145, in clause 23, page 42, line 15, at end insert—

(1B) For the purpose of determining whether to make a payment under subsection (1) and (if so) the amount of the payment, the Board must take into account at least one of the following factors—

(a) the quality of relevant services provided during the financial year;
(b) any improvement in the quality of relevant services provided during that year (in comparison to the quality of relevant services provided during previous financial years);
(c) the outcomes identified during the financial year as having been achieved from the provision at any time of relevant services;
(d) any improvement in the outcomes identified during that financial year as having been so achieved (in comparison to the outcomes identified during previous financial years as having been so achieved).

(1C) For that purpose, the Board may also take into account either or both of the following factors—
(a) relevant inequalities identified during that year;
(b) any reduction in relevant inequalities identified during that year (in comparison to relevant inequalities identified during previous financial years).

(1D) Regulations may make provision as to the principles or other matters that the Board must or may take into account in assessing any factor mentioned in subsection (1B) or (1C).

(1E) Regulations may provide that, in prescribed circumstances, the Board may, if it considers it appropriate to do so—
(a) not make a payment that would otherwise be made to a consortium under subsection (1), or
(b) reduce the amount of such a payment.

(1F) Regulations may make provision as to how payments under subsection (1) may be spent (which may include provision as to circumstances in which the whole or part of any such payments may be distributed to members of the commissioning consortium).

(1G) A commissioning consortium must publish an explanation of how the consortium has spent any payment made to it under subsection (1).

(1H) In this section—
“relevant services” means services provided in pursuance of arrangements made by the consortium—
(a) under section 3 or 3A or Schedule 1, or
(b) by virtue of section 7A or 12;
“relevant inequalities” means inequalities between the persons for whose benefit relevant services are at any time provided with respect to—
(a) their ability to access the services, or
(b) the outcomes achieved for them by their provision.”

Amendment 146, in clause 23, page 42, line 16, leave out from beginning to end of line 3 on page 43.—(Mr Simon Burns.)

Question put, (single Question on successive provisions of the Bill), That clause 23, as amended, and clauses 24, 28 and 29 stand part of the Bill.

Division No. 14]

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

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

Question accordingly agreed to.
Clause 23, as amended, ordered to stand part of the Bill.
Clauses 24, 28 and 29, ordered to stand part of the Bill.

Schedule 3

PHARMACEUTICAL REMUNERATION

Amendment made: 147, in schedule 3, page 262, line 4, leave out ‘223J and 223K(2)’ and insert ‘and 223J(3)’.—(Mr Simon Burns.)

Schedule 3, as amended, agreed to.

Ordered, That further consideration be now adjourned.—(Stephen Crabb.)

8.8 pm
Adjourned till Thursday 7 July at Nine o’clock.