Public Bill Committee

HEALTH AND SOCIAL CARE (RE-COMMITTED) BILL

Twelfth Sitting

Thursday 14 July 2011

(Afternoon)

CONTENTS

Written evidence reported to the House.
Clauses 165, 166, 176, 178 and 179 agreed to, with amendments.
Schedule 15, as amended, agreed to.
Clauses 180, 189 to 193, 242, 265, 285 and 286, 295, 297 and 298 agreed to, some with amendments.
New clauses considered.
Bill, as amended, to be reported.
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The Committee consisted of the following Members:

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

† Abrahams, Debbie (*Oldham East and Saddleworth*) (Lab)
† Barron, Mr Kevin (*Rother Valley*) (Lab)
† Blenkinsop, Tom (*Middlesbrough South and East Cleveland*) (Lab)
† Brine, Mr Steve (*Winchester*) (Con)
† Burns, Mr Simon (*Minister of State, Department of Health*)
† Burstow, Paul (*Minister of State, Department of Health*)
† Byles, Dan (*North Warwickshire*) (Con)
† Crabb, Stephen (*Preseli Pembrokeshire*) (Con)
† de Bois, Nick (*Enfield North*) (Con)
† James, Margot (*Stourbridge*) (Con)
† Kendall, Liz (*Leicester West*) (Lab)
† Lefroy, Jeremy (*Stafford*) (Con)
† Morgan, Nicky (*Loughborough*) (Con)
† Morris, Grahame M. (*Easington*) (Lab)
† O’Donnell, Fiona (*East Lothian*) (Lab)
† Poulter, Dr Daniel (*Central Suffolk and North Ipswich*) (Con)
† Pugh, John (*Southport*) (LD)
† Shannon, Jim (*Strangford*) (DUP)
† Smith, Owen (*Pontypudd*) (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

Thursday 14 July 2011

(Afternoon)

[Mr Roger Gale in the Chair]

Health and Social Care (Re-committed) Bill

Written evidence to be reported to the House

HSR 48 All Party Parliamentary Group on Complex Needs and Dual Diagnosis
HSR 49 Socialist Health Association
HSR 50 UK Faculty of Public Health
HSR 51 Royal College of Physicians of Edinburgh
HSR 52 Keep Our NHS Public
HSR 53 Association of Medical Research Charities
HSR 54 The Royal College of Physicians
HSR 55 Help the Hospices

1 pm

The Chair: Good afternoon, ladies and gentlemen. For the convenience of the Committee, I announce now that I intend to suspend the Committee at least once during this afternoon’s proceedings, to allow people to stretch their legs. Depending on how far into the night it appears we are likely to sit, I might find it necessary to suspend a second time towards 7 o’clock. There will certainly be one break—not that any members of the Committee smoke. The Chairman certainly does not.

Clause 165

Mergers

Amendment proposed (this day): 194, in clause 165, page 147, line 29, after ‘applicant’, insert ‘(that is an NHS foundation trust)’—(Paul Burstow.)

Question again proposed. That the amendment be made.

The Chair: I remind the Committee that with this we are discussing Government amendment 196 and clause stand part.

Owen Smith (Pontypridd) (Lab): It is a pleasure to serve under your chairmanship, Mr Gale. When I was speaking earlier, I was asking a few questions of the Minister. I will briefly refresh his memory with a quick run-through of those questions. When we were last talking, I could not bring to hand the National Health Service Act 2006, which is relevant to the clause, but I now have it.

The clause effectively compels foundation trusts seeking to merge to apply to and alert the regulator. My first question was: which regulator? As we learned on Tuesday, there are to be several regulators, or arms of regulators, involved in mergers: the Office of Fair Trading, Monitor and Competition Panel. The relevant section in the 2006 Act is section 56, “Mergers”, which says simply: “An application may be made jointly by—

(a) an NHS foundation trust, and

(b) another NHS foundation trust or an NHS trust, to the regulator”.

Again, which regulator? Will the Minister clarify how it will be distinguished?

When the Minister spoke to us on Tuesday, there was some confusion. He suggested that it was on our part, but I suggest that it was not entirely clear what he was saying about who will do what. I will not quote him at length, but the key question is this: is it the case that the OFT will be responsible for considering only mergers between a foundation trust and a foundation trust, and/or where the turnover of one or both of the trusts is above the £70 million threshold?

Will Monitor consider mergers between foundation trusts and non-foundation NHS trusts? I think that that was what the Minister implied on Tuesday, and the CCP thinks that that is the case. If so, what will happen to the £70 million threshold where a non-foundation trust and a foundation trust merge? Will it disapply at that point? If so, where does it say so in the Bill? That is not clear to me at all.

My third question concerned expertise: I was only halfway through it when we broke. Does the OFT have the expertise to engage in such analysis? The key point is that the Minister said on Tuesday that the OFT has discretion not to refer where patient benefit outweighs the adverse effects on competition. Patient benefit includes patient choice, innovation and high-quality service provision. What expertise does the OFT have in respect of health care? As the hon. Member for Southport pointed out, if one rings the OFT and asks to be put through to its health division, one will be told that it does not have one. I therefore contend that its evident expertise in health care is extremely limited, to say the least.

The other point that I wish to make about expertise concerns Monitor and the Co-operation and Competition Panel. On Tuesday, the Minister said that it might be suggested that Monitor could consider all mergers—NHS and private. However, there are several complications with that approach, not least that mergers is a specialist area. I agree that the Office of Fair Trading is the expert in respect of mergers in a commercial setting.

The Minister went on to say that with the lower number of mergers that will be caught under the higher £70 million threshold—it is not clear whether that applies to NHS trusts as well as foundation trusts—Monitor would struggle to build up the expertise to consider those appropriately. I thought that that seemed an odd thing to say given that Monitor is ostensibly the sector-specific expert and, as we now have learned, it will be operating through the CCP.

I spoke to people at the CCP and was told that the CCP has so far dealt with 160 mergers. When I said to the Minister on Tuesday that the CCP principally dealt with mergers, he said that it does lots of other things apart from mergers. There are some other things that it does, but so far—and this is its information—it has dealt with 160 merger cases, five to 10 conduct cases,
around five procurement disputes and two market studies. Therefore, it has dealt with 160 merger cases compared with about 20 other things. I will come back to the question on market studies in a moment.

Surely the Minister will concede that if Monitor is going to operate through the CCP, there can be no question of its not having expertise to deal with mergers, because the CCP has dealt with 160 of them. What is this issue about its not having sufficient expertise? Crucially, the question of cost then raises its head. If the CCP has successfully dealt with 160 merger cases in its short period of office, at a cost of £2.8 million per annum, can it really be necessary to create Monitor, which apparently will not have the expertise to deal with mergers, at a cost of £130 million per annum?

It would be simple if we just used the expertise of the CCP. We could easily set it up on a statutory footing. Apparently, the fact that it is not on a statutory footing is a problem because there is a danger that its words will not be heeded when it protests about the conditions of a merger. It is simple—put the CCP on a statutory footing and save £127.5 million.

Mr Kevin Barron (Rother Valley) (Lab): My hon. Friend will have read, as I am sure all members of the Committee have, that the Government’s response to the Future Forum said exactly that. It said:

“[The CCP] has dealt with 160 merger cases at a cost of £130 million per annum, but new arrangement will be needed to provide additional resources to the CCP.”

That is not the case in this Bill, and we have not been told why.

Owen Smith: I am grateful to my right hon. Friend. I am not so sure that that is the case. Perhaps they are getting a statutory underpinning, but only through being folded into Monitor. That seems to be what is happening.

Mr Barron: It is not clear in the Bill.

Owen Smith: Absolutely, it is not. It is not clear at all. My right hon. Friend is absolutely correct to say that it is not clear, and that applies to so many other things in this Bill.

What is equally unclear is how this body, which is evidently expert—it has dealt with 160 mergers at a cost of just under £3 million per year—will be configured now that it has to sit within Monitor. If Monitor will be operating through it, what happens to the way in which it is structured right now? At the moment, it has a panel of very eminent and expert people, including Lord Carter of Coles, Andrew Taylor, Guy Beringer QC, John Wooton, John Swift QC, Professor Peter C Smith, one of the world’s leading health economists, and Professor Dame Janet Husband. They are all eminent people who are expert in health care and competition law.

Are all those people being kept on in addition to the non-executive directors who will sit at the top of Monitor? Are we going to have a set of non-executive directors at the top, and then a separate panel of non-executive directors advising an arm of Monitor—“the CCP division”, or whatever it is going to be called—that will apparently have around 15 staff and is the front end in dealing with competition? It all seems a bit confused to me, so I would be grateful if the Minister cleared up what will happen with respect to the panel and how exactly the CCP will work.

The final point that I would like to raise about this merger clause is about consultation, and the nature of the consultation that FTs will have to engage in before they consider a merger. The clause completely cuts from the 2006 Act subsections (5) to (10) of section 56, which is entitled “Mergers”. Crucially, section 56(8) says:

“In the course of the consultation the applicants must seek the views of—

(a) any Patients’ Forum for an applicant,

(b) the staff employed by the applicants,

(c) individuals who live in any area specified in the proposed constitution as the area for a public constituency,

(d) any local authority”—

and so on.

That is an important clause, which essentially compels potential mergers, or mergees, to consult with the wider constituency. I would be grateful if the Minister pointed out where, under the new legislation, a similar duty is placed on them, or whether that might be specified in the licence conditions, as other things might be. Can he offer us a guarantee that that consultation will be specified in the licence conditions? I think that patients and the public around trusts that might be merged or might take up FT status would be extremely keen to hear that reassurance from the Minister.

The Minister of State, Department of Health (Paul Burstow): Thank you, Mr Gale; it is a pleasure to serve under your chairmanship for this last home stretch of our Committee deliberations.

To inform this debate on clauses 165 and 166—and, I hope, to avoid the confusion that exists around these issues—I would like to clarify what we are proposing on three related issues. I mean, first, the types of mergers that NHS trusts and foundation trusts will be able to participate in; secondly, the requirements for NHS trusts and foundation trusts to secure approval for such transactions; and, thirdly, the arrangements for reviewing the potential impact on competition of such transactions.

I should say, however, that so far much of this debate has centred on clause 71, which we debated on Tuesday. Clause 71 was about mergers in relation to activities. The clauses before us today are about organisational mergers. They are distinct things, and the opportunity to explore mergers around activities, which is what the Enterprise Act 2002 provides for, came when we were scrutinising clause 71. However, we have already raised some of these issues in this stage, so I want to ensure that there is clarity about both by the end of the scrutiny of this set of clauses. There are clear distinctions, which is, I think, why there is some confusion on the part of the hon. Member for Pontypridd and some of his hon. Friends.

For context, it is also important that this debate should recognise as a first-order issue the legal difference between the status of NHS trusts and foundation trusts. Unlike foundation trusts, NHS trusts remain subject to the Secretary of State’s powers of direction. As a
consequence, all mergers involving NHS trusts, whether these are around activities or organisational issues, continue to require the Secretary of State’s approval. Autonomous, accountable foundation trusts, however, would not be subject to the Secretary of State’s direction, as established in legislation brought forward by the previous Government in 2003, and then in 2006.

I hope that hon. Members will forgive me if I refuse to take interventions at this stage; I want to make sure that this is clearly on the record, so that hon. Members have a chance to be clear about where this all takes us.

The first issue is about what types of mergers NHS trusts and foundation trusts would be able to participate in. Legislation would permit organisational mergers between foundation trusts, between NHS trusts, and between foundation trusts and NHS trusts. An organisational merger would involve both organisations ceasing to exist and a new one being established by statutory order. Legislation would not permit an organisational merger between an NHS trust or a foundation trust and a private entity.

Joint ventures involving an NHS or foundation trust would be different again. These transactions would involve the merger of activities between two or more organisations—for example, providing pathology services, but the organisations each continuing to exist separately.

I will deal with some of the hon. Gentleman’s other specific questions, then come on to the second issue of approval requirements for mergers involving NHS or foundation trusts.

The hon. Gentleman asked about the Co-operation and Competition Panel continuing to review trust-to-trust and trust-FT mergers. The Secretary of State, as I have said, will continue to have the ability to seek the CCP’s advice on these specific mergers where it relates to an NHS trust merging or a trust and an FT merging. The OFT will not review mergers involving foundation trusts or a trust acquiring trust. However, legislation would not allow an NHS trust to acquire all or part of another NHS trust. However, legislation would not allow an NHS trust to acquire an NHS foundation trust, nor for either an NHS or foundation trust to be acquired by a private entity.

An acquisition by an NHS trust or foundation trust would be a different form of transaction, where the acquiring trust would continue to exist. The legislation would permit a foundation trust to acquire all or part of another foundation trust or NHS trust, and will permit an NHS trust to acquire all or part of another NHS trust. However, legislation would not allow an NHS trust to acquire an NHS foundation trust, nor for either an NHS or foundation trust to be acquired by a private entity.

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The hon. Gentleman asked about the Co-operation and Competition Panel continuing to review trust-to-trust and trust-FT mergers. The Secretary of State, as I have said, will continue to have the ability to seek the CCP’s advice on these specific mergers where it relates to an NHS trust merging or a trust and an FT merging. The OFT will not review mergers involving NHS trusts. As we discussed while debating clause 71 on Tuesday, the CCP will transfer to Monitor. My right hon. Friend the other Minister set out last week the basis on which that would be given effect in regulations and elsewhere.

A question was also asked about the expertise of the OFT—again, we debated that at some length on Tuesday in clause 71. The OFT has experience and expertise in regard to mergers and will always seek the views of Monitor, and through it, the CCP, on FT-to-FT mergers.

I move on to the second area, the approval requirement for mergers involving NHS trusts or foundation trusts. Any form of merger involving an NHS trust would remain subject to the Secretary of State’s approval, as now. That is not the case for foundation trusts, and clauses 165 and 166 apply to organisational mergers and acquisitions where two whole trusts merge, or a trust acquires another trust.

Clause 165 deals with a merger between a foundation trust and another foundation trust or an NHS trust, and clause 166 deals with a foundation trust acquisition of another foundation trust or an NHS trust. The current wording of clause 165(2), which deals with mergers, and clause 166(2), which deals with acquisitions, requires that foundation trusts obtain the approval of the majority of their governors before a merger or acquisition can take place. That is an important safeguard and assurance for the local community, from which those governors come, and an essential part of the increased accountability that the Government want to see in this model.

The purpose of our amendments 194 and 196 is to clarify that the requirements for governor support apply only to foundation trusts. When it comes to reviewing mergers involving NHS trusts and foundation trusts—this is the third strand—as to their impact on competition, we agree with the previous Government’s principles and rules of co-operation and competition. Those require that mergers involving NHS trusts or foundation trusts should be permitted only “where there remains sufficient choice and competition or where they are otherwise in patients’ and taxpayers’ interests”.

That was in the principles and rules for co-operation and competition that were in place in March 2010; they have not changed since the election one iota in that regard. That is consistent with the principles of the UK’s general merger control regime, as set out in the legislation introduced by the previous Government under the Enterprise Act 2002, and is reflected in the approach to merger reviews currently operated by the Co-operation and Competition Panel.

However, there is currently legal uncertainty as to when and where the 2002 Act would apply to mergers of activities involving foundation trusts. As a result, under the current arrangements for review of mergers involving foundation trusts by the Co-operation and Competition Panel, there is always potential risk of duplication or—worse still—double jeopardy.

That is why we have proposed under clause 71 that mergers involving foundation trusts should be referred to the OFT for review. That would establish a single merger control regime for foundation trusts and reflect the models of sector regulation and concurrency that the NHS Future Forum supported, and it would minimise duplication of specialist skills and expertise by doing so. We would always expect the OFT to take advice from Monitor and secure objective evidence of the costs and benefits of proposed mergers, including the likely impact on access to the quality of care.

For NHS trusts, we do not face legal uncertainty, in so far as we would not expect an NHS trust under the Secretary of State’s direction to be subject to UK merger controls of activities merging under the 2002 Act. Given that, it would not be appropriate for mergers involving NHS trusts to be referred to the OFT. In any event, we are committed to supporting all NHS trusts to achieve foundation trust status, or become part of a foundation trust in due course. However, during the transition, we would still wish to consider the potential impact on patients and patient choice, and competition...
of mergers involving NHS trusts, in line with the principles set out by the previous Government, as I have just reported. That is why the Secretary of State would retain the ability to request advice from Monitor through the Co-operation and Competition Panel, as I have set out.

I hope that I have been able to address the concerns that still seem to stem from our debate on Tuesday and the amendments discussed today.

Fiona O’Donnell (East Lothian) (Lab): The Chair: Order. I do not regard it as good practice to call hon. Members once the Minister has wound up. The Opposition spokesman has indicated that he wishes to intervene.

Owen Smith: I do not think there is any confusion among the Opposition about the extent to which the Enterprise Act differentiates activities. The Act is clear about activities that lead to two bodies no longer remaining distinct entities and, in effect, merging. The issue is the traditional non-applicability of that to NHS bodies. That is where legal doubt enters.

I am grateful that the Minister has confirmed that the OFT will not review mergers involving NHS trusts. That prompts the question I asked earlier: does the £70 million threshold not apply to that?

Fiona O’Donnell: I am grateful to my hon. Friend for those important observations. The Minister says from a sedentary position that he was quoted out of context. I challenge him to find the reference and look back at it, because I do not think he was. That comment about Scotland, Wales and foreign mergers was dropped out of a wide blue sky by the Minister, in the midst of a discussion about clause 71. At the time it raised a question in my mind: is it possible for a merger to take place between an NHS trust or a foundation trust in England and one in Scotland or Wales? I think that is wholly impossible, unless the Minister is rewriting the rules of devolution as we go along, but if it is possible to do it, that is news to us and we should be grateful if he enlightened us.

Mr Barron: Does my hon. Friend think that the Government’s response to Future Forum which talked about giving the Co-operation and Competition Panel a “statutory underpinning” to ensure it retained its “distinct identity” looks a bit thin when no changes are being proposed to statute to make good that promise?

Owen Smith: On many occasions during this long Committee, my right hon. Friend has pointed out gaping holes in the Bill and he has just identified yet another. A gaping hole that I raised with the Minister during the last set of remarks was the rationale for excising section 56(5) to (10) of the 2006 Act, which relates to consultation. I think the Minister was trying to indicate that the fact that more than half the governors of an FT would have to agree to seek a merger made it okay. I agree that that is a good provision, but I think he was implying that that was somehow sufficient safeguard for the local populace, and I am not sure that that is correct. Can he point to where else in the Bill it states, as it did in legislation introduced by the previous Government, that when seeking to merge trusts would need to go out to consultation with staff, the local populace and the local authorities. That is a crucial question and I should be grateful for an answer on that, as well as elucidation on the possibility of mergers with bodies in Wales and Scotland.

Paul Burstow: On the point that is at the heart of the hon. Gentleman’s confusion, which was rehearsed again just now, we are debating under these clauses organisational mergers—where two organisations come together and cease to exist and are succeeded by a new organisation. On Tuesday we debated mergers of activities, where two organisations—

Owen Smith: Will the Minister give way?

Paul Burstow: I am trying to deal with the hon. Gentleman’s confusion. On Tuesday we were dealing with mergers of activities and the way they are regulated now and will be in future, in relation to the Enterprise Act 2002. That was clear in the way I set it out again today. I am surprised that the hon. Gentleman found it so surprising that clause 71, which is explicit about the application of the Enterprise Act, would not therefore apply the thresholds, which I shared and which he today has acknowledged are in that Act. He only discovered that afterwards, not having done his homework beforehand.

We have set out matters very clearly. I am still puzzled by the fact that on the one hand the Opposition have deployed arguments that suggest they are wholly opposed to the notion of concurrency and having a sector-specific regulator, while on the other they seem to be in favour of it. It is not clear whether they are for or against that, which is a great pity for those outside the Committee who are trying to understand the Labour party’s position. I urge that the amendment be made and that the clause stand part of the Bill.

Amendment 194 agreed to.

The Chair: Before we proceed, let me clarify the procedure. There is no rule, but custom and practice suggest that once the Minister has been called to wind up the debate, and given that I allow, as I did, a fair
amount of time for hon. Members on either side of the Committee to leap to their feet if they wished to intervene, I would not normally expect to call anyone from the Back Benches. It is up to the Minister to decide to what extent he wishes to answer points that have been raised; that is not the duty of the Chair to determine. Where the Minister indicates that he would prefer not to give way, but is prepared to take further interventions once he has sat down, that is a different matter. That is what happened in this case. I trust that clarifies it.

Mr Hood has already indicated that he does not anticipate a stand part debate on this clause and I will now shock the Committee further by indicating that I do not propose to have a clause stand part debate on clause 166 either, because the two amendments that we are debating, with the ones that have been called, deal with acquisitions. What I am saying to the Committee is that if there are matters relating to acquisitions that Members wish to raise, they may take the opportunity to do so as and when they catch my eye, if they catch my eye.

Paul Burstow: I beg to move amendment 195, in clause 165, page 147, line 31, leave out paragraph (a).

The Chair: With this it will be convenient to discuss Government amendment 197.

Paul Burstow: The amendments would require an NHS trust to obtain the Secretary of State’s support for an application either to merge with or to be acquired by a foundation trust. The two changes together would align the requirements for Secretary of State approval for mergers and acquisitions in an organisational sense. Achieving foundation trust status is a significant step for an NHS trust; it moves from being subject to the Secretary of State’s direction to being an operationally autonomous organisation that is accountable to the patients and the community that it serves.

Section 33(1) of the National Health Service Act 2006 requires an NHS trust to obtain the support of the Secretary of State for an application to Monitor to be authorised as a foundation trust. These two amendments would extend the requirement for the Secretary of State’s support to an application from an NHS trust to achieve foundation trust status by merging with or being acquired by a foundation trust. That would ensure that an NHS trust must have the Secretary of State’s support for an application to Monitor in this regard.

Amendment 195 would therefore retain the current requirement under section 56 of the 2006 Act for an NHS trust to obtain the support of the Secretary of State in an application to merge with an FT. Clause 166 creates a new specific power for a foundation trust to acquire another foundation trust or an NHS trust. Amendment 196 would add to that by requiring that where an NHS trust is to be acquired, the NHS trust must first obtain the support of the Secretary of State in the same way as they would for a merger. The amendments, therefore, bring the requirements for the Secretary of State to support an NHS trust application to be acquired by a foundation trust into line with requirements for the Secretary of State to support an NHS trust in regard to mergers.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): It is lovely to see you again, Mr Gale. This group of clauses relates to what is at the heart of the Bill: maximising competition. The Secretary of State has said that he wants to maximise competition and create a health system in which the number of purchasers and providers is maximised, and in which a citizen-consumer competitive market drives forward the forces of “creative destruction” in the NHS. Hon. Members may remember that from earlier discussions and it does relate to the different parts of the Bill.

I can hear people ask, “Won’t constant entry and exit from the market be prohibitively expensive? After all, you can’t just set up a hospital at the drop of a hat.” That is true, unless there is a system in which the barriers to market entry and exit are low or non-existent, and that is what these clauses do. In effect, they set up a new insolvency regime for foundation trusts. The Bill allows FTs to fail and the clauses enable them to be bought out by new market entrants. We are already seeing that. My hon. Friend the Member for St Helens North (Mr Watts) has seen documents to that effect in relation to Whiston hospital; there is also evidence from Trafford health care trust as well. What about the patients in all this? The Bill pays scant regard to patients. There are no protections for them, as we are seeing with Southern Cross. The first duty of such companies is to maximise the money that the company generates for their shareholders, as enshrined in company law.

I am sure that the Government will say that I am scaremongering, but there are direct parallels between the Bill’s effect—opening up the NHS to wholesale competition, removing the private bed cap to generate income, replacing the social purpose of NHS trusts with an economic focus and allowing foundation NHS trusts to dispose of their assets as well as raise loans—and the events at Southern Cross.

The conditions that led to the failure of Southern Cross will be repeated under the Bill. In effect, it allows foundation trusts to fail and private equity companies to buy NHS facilities and equipment. That may not be confined to foundation trusts. In an article in Primary Care Today, a law firm questions what will happen to primary care estates. I urge the Government to think again, and I appeal for the support of Members who are concerned about the measures.

Owen Smith: In some respects, this is another amendment that we welcome. It clarifies that the Secretary of State must be consulted before an NHS trust, not a foundation trust, is acquired or seeks to make an acquisition. That was clear in the National Health Service Act 2006. It was also clear that the trust would have to consult its local patients, local populace and local authority, but that is no longer clear—it has been wiped from the Bill, unless I have misread it. I have twice asked the Minister about that, and he has singularly failed to comment, so I assume that I have not misread the Bill, the Minister just does not want to talk about it.

The Minister has told the Committee on a few occasions, and he repeated it today, that an NHS trust or foundation trust cannot merge with a private company, which is a good thing, but such mergers would be a bad idea. However, NHS trusts and especially foundation trusts
can acquire a private company. There is no provision in
the Bill, as far as I can see, that dictates the possible size
of such private companies.

Owen Smith: I will be explicit. I do not know about
the Minister, but I have come across things known in
the market vernacular as “reverse takeovers”, which
describes what happens when a small company acquires
a large company at a knock-down price. We all know
that is effectively a merger because, although it has been
acquired, the larger company effectively runs the smaller
company. It would be interesting to know whether there
are any provisions in the Bill that would stop an FT
from acquiring part or all of Bupa or Assura Medical,
which is part of Virgin and is active in the consortium in
the Minister’s constituency, in what would effectively be
a reverse takeover.

Dan Byles (North Warwickshire) (Con): Might an
FT’s taking over of a private company be considered
nationalisation, of which the hon. Gentleman may well
approve?

The Minister of State, Department of Health (Mr
Simon Burns): Good point.

Owen Smith: It is a slightly bizarre point. If a small
company were being taken over by an FT, what I have
said would clearly be irrelevant; it would be relevant
only if it were a very large company, or a subsidiary of
a very large company, being taken over. Let us say that a
big pharmaceutical firm decides that one of its arms
that provides services to the NHS—an arm’s-length,
stand-alone, separately listed company—can be acquired
by an FT. What certainty can there be that that is not in
effect a reverse takeover, in which the larger parent
company exercises some degree of control over the
public foundation trust?

Mr Burns: Presumably the hon. Gentleman supported
the Labour Government’s measures when they allowed
the University College London Hospitals Trust to take
over the privately owned London Heart hospital about
three years ago. The problems that he is speculating
about did not occur.

Owen Smith: I do not mind admitting when I do not
know something, so I confess that I did not know about
that. I will look into it and find out whether the London
Heart hospital is, as I suspect, a very small company. I
am intrigued to know about that.

Mr Burns rose—

Owen Smith: No: I will finish the point, because it is
not a silly point or a ludicrous one. There could well be
reverse takeovers. They happen in the business world all
the time, as the Minister would know if he had worked
in business, and it is perfectly possible to imagine that
large companies might seek to exercise greater control
over foundation trusts through their subsidiaries or
through some sort of financial engagement. In fact, I
would be flabbergasted if that did not happen at some
point.

Tom Blenkinsop: The Minister has just clarified that
mechanisms for allowing trusts to take over private
businesses already exist, so the Bill is redundant. In
addition, we are ignoring the arguments that we established
in clause 71, on which we had a tied vote. The clause
states that a trust can merge with other bodies, but it
does not define whether the most prominent position in
that relationship would be occupied by the trust or by
the other bodies, other businesses or other enterprises.

Owen Smith: That is very relevant. It is also relevant
that the £70 million threshold will not apply in respect
of non-FTs that get involved. What would happen if a
non-FT sought to acquire a private company of some
scale or description? What if that private company’s
turnover is greater than £70 million?

I would like touch on the concept of Chinese walls
within Monitor. As the architecture in the Bill concerning
takeovers, mergers and acquisitions becomes more and
more labyrinthine—[Interruption.] With respect, the
Minister, the hon. Member for Sutton and Cheam, can
read back over his extraordinarily labyrinthine description
of the architecture in Tuesday’s Committee, including
the stuff about Scotland, Wales and overseas territories,
which he has again failed to explain to us. It is labyrinthine
and confused, and I suspect that those in another place
will agree with me.

Given the confusion, I would also like to address how
on earth Monitor is going to operate the Chinese walls
that we have heard about. There will apparently need to
be Chinese walls between the parts of Monitor that deal
with competition, mergers and the regulation of the
FTs. How on earth can that occur within one building?
Each aspect will undoubtedly have a bearing on the
others. The decision about whether an FT is allowed
to merge or acquire another company is clearly relevant to
competition and to regulation. All three are interlinked,
and it is extraordinary that we are asking Monitor to be
poacher and gamekeeper—regulator and preventer of
anti-competitive behaviour, or promoter of competition,
depending on what time of the year we are talking to
the Government about it. That is an untidy and
unsatisfactory scenario. If the Minister could spell out
again—because he has failed to do so in the past—how
the Chinese walls will work in practice, we would be
grateful.

The Chair: I caution the Minister not to seek to
reopen matters that have already been debated.

Paul Burstow: Thank you, Mr Gale. The hon. Gentleman
is trying to kick some mud up, because part of the
function of an Opposition in scrutinising a Bill is to
create a sense of confusion where there is none. When
those who follow our proceedings read how we have set
out clearly the differences between mergers in respect of
activities and mergers in respect of organisations, it will
be clear—
Owen Smith: Will the Minister give way?

Paul Burstow: No, because the hon. Gentleman will be neither helpful nor informative.

Owen Smith: Will the Minister explain the difference between activities and organisations?

The Chair: Order.

1.45 pm

Paul Burstow: I want to help the Committee and I want to make progress, so that we adequately scrutinise the remaining clauses.

The hon. Member for Oldham East and Saddleworth started the debate by repeating a set of arguments that those who follow our proceedings will have noted that she has turned to on several occasions. They are truly fantastical. She wants people to accept a conspiracy theory about the Government’s intentions. The idea that the plans drive at solely competition, quite regardless of patients’ interests, is manifest nonsense. The way that the clauses are now amended makes that absolutely clear. Monitor’s role is not about promoting competition; it is about protecting and promoting the interests of patients and enabling integration.

At the heart of the reforms is the essential concept and belief that we want to hardwire into the NHS: that no decision about a patient or carer should be made without their involvement. That means in both how the NHS is run and how an individual’s health care is provided. That is an essential part of a modern, high-quality national health service. I suggest that if the hon. Lady an answer then. It might have been one of those occasions when I was giving her lots of examples of the Government’s commitments to become anti-choice, pro-poor standards of patients’ interests, is manifest nonsense. The way that the clauses are now amended makes that absolutely clear. Monitor’s role is not about promoting competition; it is about protecting and promoting the interests of patients and enabling integration.

The hon. Member for Oldham East and Saddleworth started the debate by repeating a set of arguments that those who follow our proceedings will have noted that she has turned to on several occasions. They are truly fantastical. She wants people to accept a conspiracy theory about the Government’s intentions. The idea that the plans drive at solely competition, quite regardless of patients’ interests, is manifest nonsense. The way that the clauses are now amended makes that absolutely clear. Monitor’s role is not about promoting competition; it is about protecting and promoting the interests of patients and enabling integration.

Let me deal with one or two of the issues raised by the hon. Member for Pontypridd. First, foundation trusts do not have shares. They cannot be traded on the stock market and, as a consequence of that, they cannot be acquired. We have made it clear that they are public benefit organisations.

Owen Smith: I know that.

Paul Burstow: That knowledge did not come across in the way the hon. Gentleman made his arguments. To repeat: the bill makes it clear that the guiding principle of the legislation is that foundation trusts continue to be public benefit organisations that are there to provide services to the NHS. Along with their duties to have regard to the NHS constitution, that is the ultimate safeguard. FTs cannot be taken over by private entities. We have already discussed that at length, but I want to make it clear again. FTs can, however, as they do under the existing arrangements, have joint ventures. That was fine under the previous Government and it is a good way for capacity to be extended and for services to be improved.

The hon. Member for Oldham East and Saddleworth asked whether there could be staff buy-outs of FTs. I undertook to write to her, but if I deal with that question now, that might save the correspondence. The answer is absolutely not. FTs have no equity, as I have just said, so they cannot be bought or sold. We want to encourage staff-led organisations. Indeed, the previous Government, of whom she was not part, supported the idea of the right to request for staff, and they provided public money to support NHS staff to acquire and set up social enterprises. Many of them were trumpeted by the Labour party when it was in government. We think that the idea of social enterprise is of the time, and it is something that we want to continue to support.

The hon. Member for East Lothian asked about mergers between FTs and Scottish and Welsh trusts. That probably strays back to clause 71, but it is possible that an English NHS trust could combine activities—I stress activities—with those of an NHS organisation over the border in Wales or Scotland. It is not possible, however, for the English NHS trust to merge with an organisation such as a Scottish health board. I hope that finally puts that particular concern to rest.

There was a general question about the continuing assertion that the proposals mean privatisation by the back door.

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

Paul Burstow: On that specific point?

Emily Thornberry: Yes.

Paul Burstow: I will answer a question on that specific point.

Emily Thornberry: I genuinely do not know the answer to this question, and I wonder if the Minister can help me. Will foundation trusts be able to sell off their property so that they have an operating company separate from a property-owning company, in the same way as Southern Cross did? That would be privatisation through the back door.

Paul Burstow: That was not the question that I was expecting. We had that question on Tuesday, and I gave the hon. Lady an answer then. It might have been one of those occasions when I was giving her lots of examples and there was an exchange going on across the Committee. I urge her to read Hansard, because I have specifically talked about leaseback arrangements.

The final thing I wish to say is that the hon. Member for Pontypridd has asked several times about the obligations on organisations to consult and involve the public, and I am happy to make it clear for him and other members of the Committee and beyond that we expect the licences to reflect legal requirements, including requirements for local involvement and consultation in relation to organisational change.

Owen Smith: Labour Members absolutely believe in patient choice. We introduced it. We absolutely believe in standards. We raised the standards in the NHS, as the OECD and lots of other international bodies

[Interruption.]

The Chair: Order. I am having some difficulty differentiating heckling and private conversations. I would prefer to hear neither.
Owen Smith: I am grateful to you, Mr Gale. I do not think that anyone could contend that Labour did not adequately support the NHS. We tripled its budget, I think, and built more hospitals in our period in government, which resulted in the highest standards and the highest level of patient satisfaction ever known in the NHS. We created the NHS and we will continue to support it, and people will continue to trust us to do so. Again, however, the Minister did not adequately answer the questions about acquisition, nor did he address at all—for the third time now—the question about consultation.

Paul Burstow indicated dissent.

Owen Smith: He did not, and nor did he properly address the issue of Chinese walls.

Amendment 195 agreed to.

Clause 165, as amended, ordered to stand part of the Bill.

Clause 166

ACQUISITIONS

Amendments made: 196, in clause 166, page 148, line 12, after ‘applicant’, insert ‘(that is an NHS foundation trust)’.

Amendment 197, in clause 166, page 148, line 13, after ‘must’, insert ‘—
(a) be supported by the Secretary of State if B is an NHS trust, and
(b)’.

—(Paul Burstow.)

Clause 166, as amended, ordered to stand part of the Bill.

Clause 176

ABOLITION OF NHS TRUSTS IN ENGLAND

Paul Burstow: I beg to move amendment 198, in clause 176, page 155, line 10, leave out subsections (3) and (4).

The Chair: With this it will be convenient to discuss Government amendments 224 and 226.

Paul Burstow: As I have said, the previous Government first created foundation trusts because they recognised that top-down management of all NHS providers was never going to achieve the best care for patients. Indeed, many speeches in which previous Government Ministers say just that are littered across the past six years of Hansard. Like them, we remain committed to supporting the pipeline for all NHS trusts to become foundation trusts in their own right, or part of one, so that all patients and staff can benefit from providers that are autonomous and locally accountable. Foundation trust status shows that a trust has demonstrated its clinical and financial stability and sustainability.

Our approach of setting a clear deadline for the repeal of the NHS trust legislation has already had an impact in countering the relative inertia that existed under the previous Government. That deadline has been a key determinant in the change in mindset needed to support all NHS trusts in achieving foundation trust status. We have backed up the deadline with local focus and national co-ordination and support, and are looking at areas where specific help might be needed. We have already seen a change in the mindset, and most NHS trusts have agreed good plans for achieving foundation trust status. We must ensure that that momentum is not lost.

We have listened, however, and have heard the concern that quality and patient care could be damaged if NHS trusts are pushed to apply for FT status before they are ready. We discussed that concern only this morning. We can see that some NHS trusts may benefit from more time, rather than a change in plan or management. We acknowledge that the challenges of transition to an all foundation trust sector will be considerable, but just as it would be wrong to move too quickly it would not be in the interests of patients or the public to abandon the goal altogether.

Together, the amendments remove the 2014 deadline from the Bill, as well as the related reserve power for the Secretary of State to change the date and the current commencement provisions; they do not change the proposal to repeal NHS trust legislation, or Monitor’s authorisation powers. It remains the case that it will no longer be an option to stay as an NHS trust. We continue to expect the vast majority of remaining NHS providers to meet the high standards needed to become foundation trusts by 2014 and for them to benefit from the freedom that foundation trust status brings. To do this, we recognise that some NHS trusts may need to come together, merge with existing foundation trusts, or enter into franchise arrangements. However, if a small number of NHS trusts cannot meet Monitor’s test we will not arbitrarily abolish them in their current legal form in 2014. All NHS trusts are expected to become foundation trusts as soon as clinically feasible, with an agreed deadline for every trust.

NHS trusts applying for foundation trust status will continue to be subject to stringent tests set by Monitor and there will be no lowering of the bar. In order to succeed, applicants will need to have strong boards and be financially and clinically robust. We are all agreed that it is in neither the patient nor public interest for organisations that provide poor care or are not well run to become foundation trusts.

Jeremy Lefroy (Stafford) (Con): I fully understand the reason behind the amendment. I am probably not being very clever and I am no lawyer, but if we propose to remove subsection (3) of clause 176 and the Bill becomes law, does that not mean that NHS trusts will be abolished immediately?

Paul Burstow: No, because we are making changes to the arrangements in the commencement clause which mean that we will have the ability to commence that part of the Act—when it becomes one—at a time that can be specified later. I think that is how it will be dealt with— / Interruption. / I got a reassuring nod, which is always gratifying.

In conclusion, I have set out the purpose of the amendments and beg that the Committee approves.
The Chair: Amendment 49 has not been called because it is otiose; one cannot effectively negative a negative on stand part. Given, however, that the Opposition have indicated that they wish to oppose the whole clause I am proposing to take the stand part debate now as well.

Owen Smith: I think we could call this the “shambles clause”—or the “shambles amendment”—because it is one of the clauses in the Bill that shows very clearly what an utter mess the Government have made of this legislation. It is an absolute, complete and utter shambles. Only a couple of months ago they were proposing to set the hard date of 1 April 2014. That was going to be the point at which trust status would fall, with everybody ready to be a foundation trust by then. We said at the time that that was a very bold and foolhardy commitment from the Government and so it is proven, because they have had to remove it from the Bill. In excising subsection (3) from clause 176—the date, 1 April 2014—they are clearly acknowledging that trusts will not be ready. In particular, the 20 trusts that we understand are in financial difficulty will not be ready to move to foundation trust status. This shambles is important because the Government, in creating an unholy mess and such chaos in the NHS, have made it far harder for those 20 trusts, and for other trusts that are not foundation trusts, to get ready to take on foundation trust status.

2 pm

It is absolutely not true to say that the previous Government did not push as hard as they could to get the trusts ready to adopt foundation trust status, if they so chose. The uncertainty that this Government have sown with the Bill—on top of the stringent, unprecedented savings that both this Government and the previous Government asked the NHS to make over the comprehensive spending review period—makes taking on that status far harder. The chaos makes it much more difficult to imagine that those trusts will be ready, which is why the Government have had to change the clause; it is their acknowledgement that it is extremely unlikely that all those trusts will be ready to assume foundation trust status. In proposing the amendment, the Government recognise that they are making a mess of the NHS, and they should be decent enough to say so explicitly.

John Pugh (Southport) (LD): I may be in a minority of one, but I was never seriously convinced that turning every NHS trust into a foundation trust was a good idea. I was never convinced, actually, that foundation trusts were a good idea, which is why I voted against them and why I am relatively unrepentant now. They offer strong autonomy to the organisation with a very weak model of accountability, but this afternoon, looking at a Bill that has all these other amendments, it is wholly unsatisfactory, Mr Gale. I know it is not your point of view, it is not mine, and it is clearly not the Government’s, so we have that in common.

Mr Barron: I want to echo some thoughts of my hon. Friend the Member for Pontypridd. This group of amendments distinctly reveals the shambles of a Bill—not this re-committed Bill—that was introduced a few months ago. The deadlines that were laid down were impractical. The fact that the Minister says that he has been listening makes me wonder why the Government did not listen before.

Subsection (4) of clause 176 gives the Secretary of State the power to bring into an order to use a date beyond what was originally laid in the Bill, which prompts the question of why it was not just left out. Perhaps the Minister did not want to propose an order with, potentially, dozens of hospitals included that could not make the deadline, and therefore, the Government did not want to expose problems in the original Bill by getting rid of the deadline altogether. That is no way to legislate.

It is clear in everybody’s mind that the original Bill—now re-committed—was more driven by ideology than common sense, and the clause and amendments show exactly that. What faith can people have in the Bill? In particular, there are areas that lie dormant, unamended, which we have asked questions about in the re-committed Bill proceedings. I hope, given the tight time scale—which was not altered—we have been given to scrutinise the rest of the Bill, that if changes cannot happen on the Floor of the House, they happen in another place. Somebody needs to pick up on the defects in the Bill, because some remain, in my view. It would be wrong to let this clause go, and particularly these amendments, which show what hasty legislation this is, and how different it is to what was said in manifestos, or even coalition agreements. That just shows how bad it is.

Here we are, with only a few minutes and hours left, looking at a Bill that has all these other amendments. It is wholly unsatisfactory, Mr Gale, I know it is not your problem, but as a legislator, I think it is wholly unsatisfactory that an institution like the NHS has been thrown to the wolves. We have had competition clauses and everything else thrown into this Bill; and here we see people who cannot and dare not even keep the legislation as it was, because it would expose what a tight and unrealistic timetable the original Bill gave us.

Paul Burstow: The right hon. Gentleman has made that speech several times during our consideration of the Bill. Can he or any other Opposition Member name a single non-hybrid Bill introduced between 1997 and 2010 that received more scrutiny over as many sittings as this one? I can tell them the answer: none. We have had 40 sittings, 28 in the original Bill Committee and a...
further 12 on the recommitted Bill. The reality is no number of sittings would be enough to satisfy him. Fundamentally, the Opposition are not here to scrutinise and improve; as we heard in the original Bill Committee, they are here to delay and confuse. I thought it would be worth getting that on the record.

Emily Thornberry: Will the hon. Gentleman give way?

Paul Burstow: No, I am making progress. [Interruption.]

The Chair: Order. The Minister has made it plain that he is not giving way.

Paul Burstow: I am responding in kind to the points that have been made by Opposition Members.

Mr Barron: The Minister says that the Opposition are not taking the Bill seriously. This morning and in previous sittings, Ministers have resubmitted amendments that they turned down when Opposition Front Benchers tabled them in the original Bill Committee.

Paul Burstow: I am sure—

Nick de Bois (Enfield North) (Con): Will the Minister give way?

Paul Burstow: Of course.

Nick de Bois: Opposition Members may not like to be reminded that we had a lot of clarity from the Member for Islington South and Finsbury, who regularly highlighted what she considered her wrecking clauses. We would do well to remember that.

Paul Burstow: I remember. The essence of the arguments—

Emily Thornberry: Will the hon. Gentleman give way?

Paul Burstow: Because the hon. Lady was named, I will do so.

Emily Thornberry: The Minister asked—not rhetorically, I am sure—whether another Bill between 1997 and now has had the same amount of scrutiny as this one. I ask him: has there been a Bill that has been more controversial up and down the country than this one, which is undermining our greatly loved national health service? In those circumstances, the amount of scrutiny that we have been allowed to give it is pathetic. Yes, we are against this Bill, but we also want to scrutinise and improve it, as we have done, and we have been entirely honest with him: we voted against it on Second Reading and we continue to be against it.

Paul Burstow: I was not clear what was pathetic—the scrutiny or something else. To respond to the hon. Lady’s question whether any other Bill in the last 13 years has been controversial, in a way, the Bill that introduced foundation trusts was controversial at the time, particularly on the Labour Benches, which is interesting. She asked the question, there was the answer.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): I am struggling to perceive the coherence in what the Opposition are doing. The hon. Member for Islington South and Finsbury said earlier in the Committee’s proceedings that she was actively trying to put in, as one my colleagues described, wrecking clauses. Now we are hearing complaints about not making quick enough progress. That does not add up. The hon. Member for Pontypridd has, quite rightly, been advocating in favour of patient choice, but in our previous proceedings, the hon. Member for Islington South and Finsbury questioned the basis of patient choice, which her party’s Government introduced. Does the Minister not agree that that is incredibly intellectually incoherent, and it is difficult for us to follow where the Opposition are coming from?

The Chair: Order. True or not, that is nothing to do with clause 176. We have had our fun. Can we now get back to the matter in hand, please?

Paul Burstow: Thank you, Mr Gale. My hon. Friend’s points stand on the record, and would bear repetition, but I will not repeat them.

The essence of the critique offered by the hon. Member for Pontypridd seems to be that we are to be condemned when we do not listen, we are to be condemned when we do listen, and we are to be condemned when we listen at a time that the Opposition think is inappropriate. The reality is that the Government have listened and reflected, and we have tabled amendments to the Bill as a consequence. I urge the Committee to accept them.

Amendment 198 agreed to.

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

Clause 178

HEALTHWATCH ENGLAND

Paul Burstow: I beg to move amendment 199, in clause 178, page 157, line 36, at end insert

‘; and the Commission must inform the committee in writing of its response or proposed response to the advice.’.

We tabled the amendment in response to concerns raised about strengthening the status and influence of HealthWatch England. The views of patients and other service users should be, as I said earlier, central to the role of the Care Quality Commission in regulating health and social care services, and informing the action that the CQC takes in circumstances where services do not meet essential levels of safety and quality. The Bill establishes HealthWatch England as a committee of the CQC, and with that purpose in mind, we want to go further in clarifying its role. The CQC’s new HealthWatch England committee will place the views and experiences of patients and other service users at the heart of the regulator. It will provide a direct channel for the concerns of patients and other service users to the regulator, and HealthWatch England’s committee will therefore provide the CQC with advice and information that it needs to take action where the views of patients and other service users highlight substandard service provision.
New section 45A of the Health and Social Care Act 2008, as inserted by clause 178, sets out the functions to be exercised by HealthWatch England operating as a committee of the CQC. They include giving information and advice to a range of persons, including the CQC, on the views of patients, other service users, the public and local healthwatches. Most of those persons are required, by new section 45A(5), to provide HealthWatch England with a written response to such advice. Currently, however, the CQC is not. The amendment creates that duty for the CQC.

Let me deal directly with the criticism that I am sure will be made: that the amendment is identical to one moved by the Opposition, in particular the hon. Member for Islington South and Finsbury, who made some of these points in the Committee before. I freely acknowledge that that is the case. What we have here is an excellent example of what our decision to pause, listen and reflect was all about, and how it enables us to improve the Bill—a tendency that, I have to say, I never saw Labour exhibit during my time in opposition and that party’s in government.

The Government’s original thinking was that it would have been unusual and unnecessary to require the CQC to make formal written responses to one of its own statutory committees; moreover, we wanted to avoid creating the perception that there was a highly formal relationship between the CQC and HealthWatch England. We believe a clear distinction between the two bodies is needed, and we want and expect communications to be formal but also collaborative, with a continual two-way flow of information between them. Those views have not changed: we still need a collegial approach, as well as one that is formalised by such reporting requirements. However, we have listened, heeded and reflected upon the points that have been made, both in this Committee and since. As the NHS Future Forum put it in its remarks on HealthWatch England,

“Although it is technically part of CQC, it needs to be allowed the independence to discharge its functions freely.”

The Government unreservedly agree with that view and we believe the arrangements set out in the Bill will achieve that. Nevertheless, we heard the point about changing the basis on which it should operate. That is why we have tabled the amendment.

2.15 pm

Emily Thornberry: In view of the exchange immediately before we moved on to this clause, will the Minister graciously accept that some of the amendments tabled by the Opposition were not wrecking amendments?

Paul Burstow: I am sure that some of them had a good-spirited aspect to them and were about probing the Bill; but some were undoubtedly and clearly intended, in the hon. Lady’s own words, to wreck the Bill. She made no secret of that. We have seen from the large numbers of votes against clauses that delay is part of what is taking place in the Committee.

I urge the Committee to support the amendment, which reflects the views of the NHS Future Forum.

The Chair: Order. I have looked through the amendments and it is apparent that, by the time we get to the end of this free-standing one and the next group, we shall, in effect, have debated the clause. I therefore say to the Committee that we shall not have a clause stand part debate. Hon. Members from all parties may wish to take cognisance of that when contributing to debate on the amendments.

Liz Kendall (Leicester West) (Lab): It is a pleasure to serve under your chairmanship, Mr Gale. You are firm but fair, and I am grateful to you for explaining some of the labyrinthine traditions of Bill Committees.

I am glad that the Minister acknowledged that Opposition Members were right. I want to make three points—

Mr Burns: Briefly.

Liz Kendall: It is funny the Minister says that, because my first overall concern about the establishment of HealthWatch England is that the Government are being unambiguous about putting patients and the public at the heart of the NHS and giving them a stronger and more powerful voice. As ever, Opposition Members are the real modernisers and reformers. We are the ones on the side of patients and the public. If we were in government, we would have had a far stronger and more independent HealthWatch England.

That reminds me that during the previous Committee scrutiny, the Minister of State, the right hon. Member for Chelmsford and discussed several times whether HealthWatch England was independent. I questioned him on whether it was right that HealthWatch England should be a sub-committee of the Care Quality Commission.

Mr Burns: It is not a sub-committee.

Liz Kendall: He says, from a sedentary position, that it is not a sub-committee. On 15 March, as recorded in fabulous Hansard, he says,

“I must tell the hon. Lady that I think it is a little unfair to refer to HealthWatch in a derogatory way as a sub-committee of the CQC.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 696.]

However, on page 38 of the Government’s response to the Future Forum, paragraph 4.39 states:

“We will…introduce a new requirement for the Care Quality Commission to respond to advice from its HealthWatch England sub-committee.”

Mr Burns: The hon. Lady still does not get it. What we object to is the derogatory way in which she classifies it as a sub-committee. That is our argument with her.

Liz Kendall: The Minister sounds as though he could be a member of the Labour party, with his knowledge of sub-committees. I am criticising the lack of independence for HealthWatch England. That is my first point.

Secondly, the proof that HealthWatch England is not strong or powerful enough comes when we assess the stature, power and resources it will get, compared with other bodies that are being set up, such as the new
economic regulator, Monitor. The right hon. Gentleman confirmed to the re-committed Bill Committee that the cost of new Monitor, which is currently £20 million a year, will increase to between £50 million and £80 million a year, so Monitor will get each year an additional sum of between £30 million and £60 million. The impact assessment for the original Bill—nothing in the amendments would change the core functions of HealthWatch England—states that HealthWatch England will receive £3.5 million a year. HealthWatch England, the new, supposedly powerful voice will get three and a half million quid to do its job, whereas Monitor gets up to £60 million extra resources a year to do the job. As Bernstein and Woodward said, “Follow the money”. We have followed the money and we can see that the power—

Mr Burns: Woodward and Bernstein, actually.

Liz Kendall: It does not really matter in which order I refer to them.

Mr Burns: It does to them.

Liz Kendall: Journalists worrying about their status—let’s not go there.

My third point is a question for the Minister and a practical and constructive suggestion of help for the Government. I may have got this wrong; if I have, I hope I will be forgiven. As I understand it, both HealthWatch England and local healthwatch will come into being by October 2012. The National Association of LINks Members submitted evidence to the Committee on 2 July saying:

“HealthWatch England is to be established at the same time as Local HealthWatch. This makes no sense. It is needed in October 2011 to pave the way, in collaboration with LINks, the NHS and local authorities for local Healthwatch which start in October.”

Will the Minister consider bringing forward the timetable for HealthWatch England’s establishment, so it can be there to get things going? Will he also explain why the Government have had so little ambition about putting patients and the public at the heart of the NHS? Will he give serious consideration to giving HealthWatch England a stronger voice and greater independence, so it can do what it says on the tin?

Tom Blenkinsop: Fundamentally, HealthWatch England is a good idea and welcome, because it will provide patients with a greater opportunity for engagement. The real issue is that to be truly effective HealthWatch England must be an entirely independent advisory body, but in its current conceptual form, it is not quite there yet. The Government have missed an opportunity to act upon their own listening exercise and the Future Forum recommendations.

Nothing is more evident of that than the fact that HealthWatch England will still sit entirely within the CQC. In the Government’s new architecture for the NHS, there will be three big players: the NHS commissioning board, run by Sir David Nicholson; the CQC, which will ensure that basic standards of care are met, run by Cynthia Bower; and Monitor, which will promote competition as a means of improving quality, as the Government claim, run by David Bennett—for now, apparently. However, there will be a fourth crucial arm, which is a much stronger voice for patients and the public. I do not agree with the Government’s approach. I firmly believe that, if patients and the public are to have a far greater say, the body to achieve that should be more important than the other three bodies. HealthWatch England should be independent.

HealthWatch England will lack independence because it will sit within the CQC, which creates two problems. It will have to work closely with the CQC, as it will with the other bodies, including the NHS commissioning board, so that it can ensure that information is passed up through the CQC to allow it to conduct inspections and investigations. However, what if HealthWatch England thought that the CQC had failed to do its job or work as effectively as it should?

The other problem is resources. By the end of 2012, the CQC has to register 30,000 new providers, including 9,000 providers of primary medical services, which have never before been registered, and 12,500 new providers of social care. In addition to those providers, the CQC also has to inspect and register individual sites, which, as the hon. Member for Stourbridge mentioned, is a huge task. The Ministers know about those concerns, which are being looked into, but the CQC’s resources are, like those of other arm’s-length bodies, being reduced, despite its huge tasks, and there is a real concern that HealthWatch England might not receive sufficient resources. My colleagues and I will be grateful if the Minister guarantees a ring-fenced budget.

How can HealthWatch act as the Minister envisages when it is situated within the CQC? How can it function independently when it will effectively be line managed by the CQC and, simultaneously, its chair will be line managed by the Secretary of State? The chair of HealthWatch England might have been appointed by the Appointments Commission, as mentioned in the original Committee by my hon. Friend the Member for Leicester West, but that is no longer possible because the Government have abolished the Appointments Commission, too. I cannot see how HealthWatch can behave freely, independently or robustly enough to hold its line manager, the CQC, to account. Is not the real danger that HealthWatch will be created with all the negative aspects of a quango, but without any of the benefits of being an independent body?

The Government had not acted to fulfil their promises to the Future Forum until Monday, when, fortunately, a few new amendments were tabled. Having looked at the their promises to the Future Forum, we expected the Government to introduce an explicit requirement that local healthwatch memberships be representative of different users, including carers. Fortunately that has now been done. The Government also agreed to introduce a new duty on health and well-being boards to involve users and the public, but, until Monday, that had not been done. My colleagues and I are predisposed, both politically and on an everyday level, to optimism, so I endeavour to be as positive as humanly possible about the Government’s amendments. Amendment 200—

The Chair: That is in the next group.

Tom Blenkinsop: Sorry, Mr Gale. We welcome amendment 199 as a positive amendment, because it places a statutory duty on the CQC to inform HealthWatch of its response or proposed response to HealthWatch’s
[Tom Blenkinsop]

advice. The amendment also fully delivers on the Government’s promise, on page 38 of their response to the NHS Future Forum report, to “introduce a new requirement for the Care Quality Commission to respond to advice from its HealthWatch England subcommittee”. I would go so far as to say that I wish the Opposition had written the amendment—that is how upbeat I am. I have good reason to be upbeat, because when reading the Hansard of the original Bill Committee, I came across our debate on Opposition amendment 348, which bears an amazing resemblance to Government amendment 199, even after the expensive listening exercise.

I assume that the Minister’s attitude is as positive as mine, so I shall read out his response to amendment 348 to check whether he still agrees with what he said then:

“Opposition amendment 348 would require the CQC to respond in writing to advice and information that it receives from HealthWatch England committee. I sympathise with the point the Opposition are trying to make on behalf the Patients Association, with the intention of ensuring that HealthWatch England is able to have its own distinct identity within the CQC. However, the amendment could work against the building of effective working relationships between HealthWatch England and the CQC. Staff working for the committee and the wider commission should be having an open and ongoing dialogue about their work. Formalising that as the amendment proposes would give the impression that communication between the committee, with its independent role, and the CQC should be conducted by means of correspondence rather than open and ongoing dialogue. For that reason, we do not support that approach to prescribing the nature of that relationship.”—[Official Report, Health and Social Care Bill Public Bill Committee, 10 March 2011; c. 610.]

After an excruciatingly expensive listening exercise, the Government have finally been able to recognise that the measure makes good sense.

2.30 pm

Given that the number of quangos in the NHS is set to explode as a result of the Bill, is it not entirely possible that HealthWatch could be swamped by the sheer number of bodies that it needs to check on and deal with? What guaranteed, recognised time would HealthWatch have to raise its concerns? Does the Minister feel that HealthWatch’s impact will need to be increased or diminished, when the board will have to listen to an ever-increasing number of clinical networks? Will he comment on whether HealthWatch’s day-to-day influence will not be marginalised?

Essentially, for the average patient to be satisfied in the environment that the Bill creates, the Government must be clear about where HealthWatch’s advice will sit. Where will I, as a patient, take my case locally? What opportunities will I, as a patient, have for input? What will the general structure be? Will there be different structures at local level, or similar structures? Will those local structures be constitutionally different or similar? The proposals have obvious implications for transient populations and could lead to inequalities of opportunity for those who wish to seek redress in different localities. Furthermore, varying structures lead to varying levels of remuneration.

How will I as a patient know where to go? What is the budget for local, regional and national advertising to spread knowledge of HealthWatch and how will patients be consistently consulted?

Karl Turner (Kingston upon Hull East) (Lab): For the benefit of the Minister, I also have speaking notes. However, I can assure you, Mr Gale, that I, unlike the Minister, prepared the notes that I am speaking from. Opposition Members have seen time and again that Ministers do not seem to have a clue about what they are saying. They seem to make it up as they go along, looking occasionally to the civil servants for support.

This is not a particularly controversial part of the Bill—

Mr Burns: Which is why he is going to talk about it.

Karl Turner: Did the Minister want to intervene? No. This part of the Bill is not especially controversial, but it is important. I am particularly concerned about the independence of HealthWatch and the lack of a voice for children and young people in the Government’s proposals. I welcome the fact that the Government have listened to the Opposition, but there are issues outstanding that we ought to consider.

Although it is to be an arm of the Care Quality Commission, HealthWatch will need to be equipped with the freedom it needs to perform its functions effectively. In that, I am in agreement with the Future Forum. I am concerned about the degree of freedom afforded to HealthWatch England by the Bill. The Patients Association has highlighted that concern in its written evidence, stating that

“HealthWatch England’s position within the CQC compromises its independence – this conflict needs to be resolved.”

The Minister needs to act to defuse that potential conflict. What can he say to the Committee to allay those concerns? It is vital, as the Future Forum and Patients Association have highlighted, that HealthWatch’s independence is guaranteed. I welcome, as everybody would, greater accountability and public participation in the national health service, but if the Minister fails to address these concerns and if HealthWatch England is kept on the CQC’s leash, it will lack the necessary bite to discharge its functions effectively.

A voice for children and young people is vital. The NHS Future Forum was clear in its prescription for representation of children and young people, but the Bill makes no reference to that group in relation to either HealthWatch England or local healthwatch. The Royal College of Paediatrics and Child Health has rightly argued that the reforms have been lacking in providing the structures and frameworks for young people and children to be properly represented. That group must be given a voice. They are too often ignored or disregarded by this Government. How will their views be represented on HealthWatch England and local healthwatch?

In the Government’s response to the Future Forum, they committed to amending the Bill to add a requirement that HealthWatch membership be representative of different users. The Government have tabled several welcome amendments, as I have already said, but there is still too little mention of children and young people in the Bill and the Government’s changes. Will the Minister respond to my concerns and those of the Royal College of Paediatrics and Child Health and the National Children’s Bureau? What are the Government doing to ensure that children and young people will be properly represented on HealthWatch?
I said that this part of the legislation is uncontroversial because the Government’s plan is to privatise the NHS—I see hon. Members on the Government Benches looking extremely confused, but that is my submission—so this section is relatively uncontroversial given the rest of the Bill. The Minister has a habit of brushing any criticisms aside, but the issues need to be addressed.

Fiona O’Donnell: I begin with two apologies, Mr Gale. First, I apologise for my absence. I wanted to take part in the debate on the closure of coastguard stations. Secondly, I will also be referring to notes that I prepared myself, but I will have to hold them close by, because I left my glasses in the room after a previous sitting of the Committee. I returned last night to try to find them, but they were not here. However, I am now a member of the all-party group on Kashmir, and I had my photo taken and made a short speech. [Laughter.] This job is offering me so many new opportunities.

I suppose that, given the hasty arrangements of this partnership, we should have expected shotgun legislation, and, with reference to clause 178, its legitimacy is not improved. Government Members have accused us of scaremongering, but, as my hon. Friend the Member for Kingston upon Hull East said, concerns are not just coming from Opposition Members; they are also coming from patients and patient organisations. The Government need to listen. However, I welcome the fact that the Government are so enthusiastic about equality duties that they are now part of HealthWatch England’s duty.

This is an opportunity to create a strong voice for patients, but if it is to live up to its objective it must have clarity in its purpose and operation. I am afraid that, as far as patients are concerned, that clarity is not there at this stage. Goodness knows the Bill in its entirety has created enough confusion. Patients need to know where to go to when they have a complaint or when they want to influence the shape of services. If they are to meet these objectives it must be clear how HealthWatch England and local healthwatch organisations will be accessible, user friendly, inclusive, properly resourced, independent and autonomous.

First, on accessibility, the Department of Health has already said that there will not be a budget for advertising to tell patients how all this fits together and where they can go to make their voices heard. I hope that the Minister will reassure us as to how patients and carers will become aware of HealthWatch’s duties and how they will be able to contact it.

Regarding the user friendly and inclusive aspect, my hon. Friend has already mentioned how important it is that the voices of children and young people are heard. I hope that the Minister will tell us how that will be realised by the clause. Also, what advocacy will be provided for people with learning disabilities, those people who are unable to speak for themselves, so that their views and input can be heard and valued?

In terms of independence and autonomy, it is important that HealthWatch is seen not just as part of the Care Quality Commission, but as an independent body with a clear and distinct role. Looking at local organisations and how local authorities, may have responsibility for funding back on? The Government must respond to these legitimate concerns and clarify the relationships. When an NHS or social care service crosses local authority boundaries, where will local healthwatch organisations feed in those views? How will the weight be divvied up—I hope that that is not just a Scottish expression—between the two?

In terms of funding, at a time when local authorities are under such pressure, how can we be sure that the necessary money will be available to give bodies the independence and resources they need? I seek reassurance on those points and look forward to hearing the Minister’s response, because this is an opportunity to ensure that patients genuinely have a say, but the Government must be much clearer about what they want to achieve with the clause. They must tell us how they will provide the support and training so that this is not just about tokenism. When views from HealthWatch on how it feels about the service are put to the various bodies—the Secretary of State, Monitor—that individual or body must not simply have a duty to record receipt. Their response and the action that follows complaints must also be in the public domain.

Nicky Morgan (Loughborough) (Con): It is a pleasure to speak under your chairmanship, Mr Gale. I will speak briefly because I was not going to speak on these clauses. However, as the Minister knows, the issue of patient and particularly public involvement has always been very close to my heart and I have mentioned my thoughts in this area many times. The comments from the hon. Members for Middlesbrough South and East Cleveland and for Kingston upon Hull East prompted some thoughts, so there are some things that I want to put to the Committee.

The hon. Member for Middlesbrough South and East Cleveland talked about three main bodies in the NHS: the commissioning board, the CQC and Monitor. He also talked about the importance of patient and public involvement, and I agree with him. The tragedy of this Committee is that we have spent so long talking about bodies that are irrelevant to patients and the public. When people go to their GP or hospital for treatment, they are not necessarily worrying about competition, patient caps, tariffs and everything else. What they want is good treatment.

2.45 pm

The hon. Member for East Lothian is absolutely right. If someone is unhappy about treatment, they want somewhere to go and complain or express thoughts. If someone suffers from a long-term condition—hon. Members will know I have spoken about mental health issues a number of times—they want somewhere to go and put thoughts about treatment and care pathways, and be heard. That is why these clauses dealing with HealthWatch England, local healthwatch and the health and well-being boards are so important. It is a shame that, because of everything else we have discussed for so many sittings, we are only now getting to them.

Liz Kendall: The reason we have got to these clauses only today is because the Government put knives in for the days when matters would be discussed. They set out which clauses would be discussed on which days. That is the reason we have reached them only today.
Nicky Morgan: The hon. Lady, like me, is a new Member, and we are all learning about parliamentary procedures together. One of the frustrations of the Bill has been all the discussion here and outside. I hesitate to use the word scaremongering, but it is true about the way it is to be worked out. We are forgetting the patient and public involvement. The hon. Lady may well be right about parliamentary procedure, but there is no doubt that hon. Members, particularly Opposition ones, have spent a lot of time talking. There is no reason why, if we had got through clauses earlier, we could not have rushed on to talk about these sooner.

Tom Blenkinsop: I generally respect what the hon. Lady says: she often makes this point. Amendment 199 is effectively a replica of our previous amendment 348. A number of the amendments that we will discuss later came through only on Monday.

Nicky Morgan: I hear what the hon. Gentleman says. The Minister mentioned the listening exercise, which has happened. There are points that were discussed previously that have been re-emphasised outside this House, and then brought before the House in the amendments.

Fiona O’Donnell: It is not only Members here who have complained about the lack of time. Every single organisation that gave evidence also said it had not had time to consider.

The Chair: Order. We have a limited amount of time. We either debate the Bill or the timetable motion. The timetable motion has already been debated, so let us get back to the clause under discussion.

Nicky Morgan: I hear what the hon. Gentleman says. I will take the Chair’s ruling. There are three points I want to make. First, the hon. Member for East Lothian mentioned local healthwatch. My understanding is that local healthwatch will play just as critical a part as HealthWatch England in raising patients’ concerns. We should not forget that it will take quite a lot of the burden.

The CQC will have to respond formally in writing to HealthWatch England. Ministers will have heard earlier of concerns from all parties about the burden on the CQC and the way it exercises its powers. It is a good thing. I echo the hon. Member for Leicester West in saying that HealthWatch England in raising patients’ concerns. We have already said that, and I invite him to put that on record.

A more important point—not just in the Bill but across Government—is that for a lot of these bodies it is about having the right people and the right ears listening. We can talk about money and budgets. We as Members of Parliament do not get advertising budgets, but people know where to come and find us.

Fiona O’Donnell: We do.

Nicky Morgan: Well, perhaps the hon. Lady has had more success with IPSA than I have had. If the right people are in position doing the right job and are the right advocates, there is a lot that can be done in telling the public how to come and describe the treatment they have had. We should worry less about process and the way that Committees are constituted. We should get the right people in, because they have the right ears for hearing about cases of bad treatment, or listening to people with long-term conditions making it clear how care pathways can be improved.

Paul Burstow: We have had a good and thorough debate, and while perhaps the tone has not suggested it, there is a good deal of consensus across the Committee about the importance of this particular clause and amendments. There is a shared purpose, it seems, about how we can strengthen patient involvement in the NHS.

However, I detect a slight contradiction in some of the arguments, in that again we seemed to be condemned when we do listen and condemned when we do not. I suppose the luxury of opposition is to be able to condemn both. It certainly seems to have been the substance of these particular points. In passing, I want to pick up on the comments by hon. Member for Kingston upon Hull East about involving young people. I very much agree with him and I want to say what we are doing on that.

The hon. Gentleman also makes some passing references to the hard work and diligent support that Ministers receive during Committee deliberations to ensure that we are properly briefed as the Committee progresses. I for one am very grateful for that. Having sat on the other side of the Committee for many years, I have seen the frenetic activity that exchanges across the Committee sometimes involve. But it is not a new feature of the Committee that has suddenly emerged since the election. It is something that has always happened, and is just a natural part of the process of—

Grahame M. Morris (Easington) (Lab): Will the Minister give way?

Paul Burstow: No.

Karl Turner: On a point of order, Mr Gale—

The Chair: It had better be a point of order.

Karl Turner: My point is that the Minister made reference to one of my hon. Friends from a sedentary position. That was what I said at the outset of my speech, and I ought to be allowed to have that on the record.

The Chair: Mr Turner, you have to differentiate between a point of order and a point of debate. That is a point of debate.

Paul Burstow: I have put my point on the record, and that was the purpose I was trying to achieve as well. I want to begin by reading from the Hansard report on 28 June when we were considering the evidence from various witnesses. I agree with a point made by Jeremy Taylor, who said:

“I am not sure that it matters where HealthWatch England sits.”—[Official Report, Health and Social Care (Re-Committed) Public Bill Committee, 28 June 2011; c. 67, Q142.]
That is quite an important point from the person who leads National Voices. He went on to say:

“...what matters is whether it has clout, credibility, independence and sufficient resources.”—[Official Report, Health and Social Care (Re-Committed) Bill, Public Bill Committee, 28 June 2011; c. 67, Q142.]

I reject the notion that the Government lack ambition when it comes to involving patients. I find it curious that after 13 years of having the opportunity to do this—

**Liz Kendall:** I was not here.

**Paul Burstow:** Of course, the hon. Lady was a special adviser at various stages of her career, and she was involved with a party that was in government for 13 years. While she may wish to disown those 13 years, they were an opportunity to do something—

**Liz Kendall:** I am incredibly proud of what the Labour Government did, and I would not disown any of it, but the Minister would accept that we were always determined to do more. More could be done to put patients at the heart of the NHS, and we have tried to be constructive in suggesting to the Minister that the Bill is not ambitious enough and will not achieve that.

**Paul Burstow:** I will take from that that the hon. Lady accepts that it was unfinished business, and we know it was unfinished, not least because during those 13 years we saw the abolition of community health councils, which were replaced with patients forums, the establishment of a Commission for Patient and Public Involvement in Health—which I believe was largely loathed by local patient organisations—and the final iteration, or attempt, to get this right under Labour: the introduction of local involvement networks. When we talk about a shambles, that epithet might apply to the endeavours of the previous Administration in this area.

However, the hon. Lady makes some important points about the timing of the establishment of HealthWatch England. She discussed the concerns of a number of organisations, and I am aware of those concerns. We are determined to do as much as we can to bring forward the date at which HealthWatch England can be established, for the very reasons given by outside organisations, as they have an important part to play both during the transition and in ensuring that the new structures work. I hope that that reassures the hon. Lady about the work of HealthWatch England. She also asked about local healthwatch.

**Liz Kendall:** I did not.

**Paul Burstow:** In that case, for her information, there is also a programme of early implementers with regard to local healthwatch. She also asked about funding. HealthWatch England, as a committee of the CQC, will have £3.5 million to help with its start-up and estimated ongoing costs. As I said when we debated this in March, the CQC will provide infrastructure such as IT, and financial and other expertise. In effect, it will have access to the resources that the CQC has as well.

**Fiona O’Donnell:** In that list, the Minister did not mention training. If we are serious about involving young people or those with learning disabilities in this process, is there a budget for training and supporting them?

**Paul Burstow:** Training is an essential part of making sure that the committee does its job, but also training at a local level for local healthwatches. That is one of the things we are exploring through the early implementation of local healthwatches.

I was also asked whether the CQC had failed and whether a body that was part of the CQC could blow the whistle on it. Healthwatch England certainly can do that, because of the clear statutory independence that the Bill provides. If it considers that it is appropriate to advise the Secretary of State on relevant matters within its remit, then the Secretary of State, under the amendments and other changes we are making in the Bill, will have to regard advice on how he discharges his functions with regard to an organisation’s failure.

Healthwatch England can therefore formally advise the CQC, which would have to respond—this is one of the amendments that we will come to later—and Healthwatch England could publish that advice. It can raise an issue with the CQC, the CQC has to have regard to it, and their exchanges can be published as well.

The hon. Member for Middlesbrough South and East Cleveland made a number of points and a key question I want to address is who do people complain to. If someone has a complaint about a service that they received from a provider, they would write to the provider. I would imagine that, as a constituency MP, that is what the hon. Gentleman does now, so he would write to the NHS trust or the foundation trust that provided the service.

If the issue was about a service that was not well specified, the hon. Gentleman may well choose to write to the local commissioner, so he would write to the clinical commissioning group. If he continued to have concerns, he could raise them with the local healthwatch and seek its support. Ultimately, if he felt that the complaint had not been dealt with satisfactorily through the various stages that each organisation would have to set out, he could take it up with the health service ombudsman. There are therefore a number of stages that he or his constituents could use to proceed with a complaint.

The hon. Member for Kingston upon Hull East spoke about the importance of involving children and young people, and I know other hon. Members share that view. It is important to make sure that, as organisations are established nationally and locally, they hear and respond to the voices of young people. That is particularly the case in later amendments which deal with representativeness. The measures capture that concern, and we should make sure that in establishing those bodies they involve young people.

I will give a couple of examples of good practice. The first is the work of the National Children’s Bureau, which runs a young inspectors programme, which is a good model of how local healthwatches could engage with young people and use their eyes, ears, views and imagination to improve services for them. That is one of the things that we want to explore through the early implementers programme.

It is worth putting one other example on record. We are in the process of redesigning child and adolescent mental health services in England to extend the idea of talking therapies to young people. That is something...
new that the Government have committed themselves to implementing, and we are working with Young Minds, an expert charity in the field, which is bringing young people directly into the process of redesigning the services. That is a model of how services should be redesigned in future, ensuring that they are tailored to the experience and expertise that young patients can bring to services, and it is very much at the heart of how we want the NHS to be reformed.

Fiona O’Donnell: The Minister is being very generous in accepting interventions. Given that local healthwatch organisations follow local authority boundaries and that public health duties will sit with local authorities, will local healthwatch organisations have any role in feeding into the development of public health campaigns and in ensuring that young people’s voices are also heard in those?

3 pm

Paul Burstow: Yes, absolutely. That is an essential part of how the new architecture fits together. There are many good examples of local authorities doing just that sort of work, and as they take on their new public health responsibilities there will be ample opportunity for more of it.

Mr Steve Brine (Winchester) (Con): Young Minds in Chandlers Ford in my constituency came to see me recently, fired up by the Minister’s plans. It said: “Thank goodness the Government are finally listening to people like us.” I just want to place on record the fact that Young Minds is an excellent organisation, which gives young people a real chance to get involved. Well done to the Minister.

Paul Burstow: I am grateful to my hon. Friend. Young Minds has had some appropriate promotion. It does good work, and I am grateful to the hon. Member for Kingston upon Hull East for raising that important matter.

The hon. Member for East Lothian asked about the establishment and constitution of HealthWatch. Given that local healthwatch organisations follow local authority boundaries and that public health duties will sit with local authorities, will local healthwatch organisations follow local authority boundaries and that public health duties will sit with local authorities, will local healthwatch organisations have any role in feeding into the development of public health campaigns and in ensuring that young people’s voices are also heard in those?

In conclusion, we are trying here to establish HealthWatch England on a firm foundation, grounded in but independent of the CQC, to ensure that the patient voice is at the heart of the delivery of services that properly meet their needs. The amendment is modest, and I hope that it will be agreed to.

Amendment 199 agreed to.

Paul Burstow: I beg to move amendment 200, in clause 178, page 158, line 31, after ‘discharge’, insert ‘, and that the failure is significant’.

The Chair: With this it will be convenient to discuss Government amendments 201 to 203.

Paul Burstow: The amendments are about what happens if HealthWatch England fails to perform its functions. They are part of a series of amendments, which we have considered and will continue to return to during the remainder of today’s sitting. They ensure that the Secretary of State has intervention powers in the event of significant failure, and that his overarching duties to promote a comprehensive health service can be given effect by that ability to intervene.

Amendment 200 agreed to.

Amendments made: 201, in clause 178, page 158, line 34, at end insert—

‘( ) In subsection (2A) of that section (inserted by section[Failure to discharge functions]), after “(1)” insert “or (1A)”.’.

Amendment 202, in clause 178, page 158, line 37, at end insert—

‘( ) In subsection (4) of that section (inserted by section[Failure to discharge functions]), after “(1)” insert “, (1A)”.’.

Amendment 203, in clause 178, page 158, line 37, at end insert—

‘( ) For the title to that section substitute “Failure by the Commission or HealthWatch England in discharge of functions”.’.

—(Paul Burstow.)

Clause 178, as amended, ordered to stand part of the Bill.

Clause 179

Establishment and Constitution

Paul Burstow: I beg to move amendment 205, in clause 179, page 160, line 5, at end insert—

‘( ) In Part 1 of Schedule 19 to the Equality Act 2010 (bodies subject to public sector equality duty), after the entry for the Health Service Commissioner for England insert—

“A Local Healthwatch organisation.”

The amendment ensures that HealthWatch England, like other bodies in the NHS, is subject to the public duties in regard to the Equality Act 2010.

Amendment 205 agreed to.

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

Liz Kendall: I want to make some constructive comments about how the Government’s plans for local healthwatchers could be bold, ambitious and really put patients at the heart of local health services and local social care services.

I have two overall points to make relating to a lack of independence and of funding. Even though I am a Front-Bench spokesperson, I hope that it is permissible
for me to talk about what has happened in my own area and about my discussions with Leicestershire LINks, which represents patients throughout Leicester and Leicestershire and is based in Beaumont Leys in my constituency. I received an e-mail yesterday from Geoffrey Smith OBE, who is the chair of Leicestershire LINks, a member of two local involvement networks, a patient adviser in an NHS acute trust, a member and a chair of a patient and public involvement forum and who has experience as a company director and chief officer in a local authority. I set out his background to show that he is a very experienced man working in health and local government. He makes an important point in his e-mail:

“By creating HealthWatch the Bill offers an opportunity to avoid past mistakes in the involvement of patients and the public in health and social care. I regret that unless the Bill is amended HealthWatch will fail to meet the vision of an informed consumer champion for health and social care set out for it in the White Paper.”

He also said:

“Local HealthWatch will not be seen by patients and the public and particularly by users of social care services as independent. A body that is commissioned, funded and performance managed by a Local Authority is perceived to be subject to influence, direct or indirect, by the officers and Members of the Council and so unable to make unbiased reports and interventions.”

His view as a local LINks person is absolutely backed up by the National Association of LINks Members which, in written evidence to the Committee on 2 July, said:

“If Healthwatch is made accountable to the local authority the public will have no confidence that it will stand up for them when things go wrong.”

Similarly, National Voices said in its paper for the NHS Future Forum listening exercise that local healthwatch should be

“genuinely independent of both NHS and local authority interference.”

It is obvious that those who are funded through local councils will be less likely to want to criticise the social care or other services that are provided more generally. The recent terrible events at Winterbourne View demonstrate why it is so important that users and carers have a strong and independent voice. The National Association of LINks Members, says:

“The simple practical solution is for Healthwatch to be funded by Healthwatch England.”

There would be a separate funding stream, so that it would not be made through the local authority—

[Interruption.] The Minister, the hon. Member for Sutton and Cheam, from a sedentary position says, “Extraordinary”. I thought they were supposed to listen. I am trying to be constructive. The National Association of LINks Members does not believe that the Government’s proposals for LINks will give them a strong or sufficiently independent voice. That is not extraordinary. It is a fact.

Grahame M. Morris: A moment or two ago, the Minister said that the Opposition had changed their stance after leaving government. Just in relation to the point we raised about nursing home registration, it is ironic that the Minister of State, the right hon. Member for Chelmsford, back in 2004 when he was the Opposition spokesman, was extremely critical of the regulatory regime which he described as “overprescriptive, expensive and bureaucratic”. He said that it was very damaging to the home care sector.

Mr Burns: It was.

Grahame M. Morris: It is interesting that you level that criticism at us when you yourself have changed your position in calling for—

The Chair: Order. The hon. Gentleman really must use the third person. This has nothing to do with the Chair.

Liz Kendall: My hon. Friend has made the point that the previous Government were often criticised for over-regulation. We need to take a long, hard look at the issues around regulation.

Dr Poulter: The hon. Lady is making some good points. However, there is concern in many communities, certainly in my area in Suffolk, that LINks are not accountable for the money that they are given to investigate and represent patients. Often the agenda of one or two individuals can skew the whole agenda of what a LINk is trying to do. The issue of accountability for the several hundred thousand pounds it receives is not properly addressed, and it would be better addressed if it had a closer link with the local authority.

Liz Kendall: The hon. Gentleman makes a very good point. Whether it is under LINks, the old CHCs or whatever patient and public involvement mechanism is available, there is always a danger that the organisation is not genuinely representative of the local community but has been captured by one or two individuals. I accept what the hon. Gentleman says about the fact that being part of a local council might give such an organisation greater democratic accountability, but anybody who has run an organisation that is solely reliant on funds from a local council, such as a local charity, will know that it can sometimes make people worry about speaking out. Sometimes they do; sometimes they do not; some charities do not care. They will go out there and champion their cause wherever they get their funding. Others are nervous.

I am reporting the views of the National Association of LINks Members and the LINks in my own patch, as it is my job to do so. However, not only am I doing that, but I am reporting the view of National Voices, which is the Government-run body, and the Minister should listen to it.

3.15 pm

The issue of money and resources available for the local healthwatch has been raised with me by my Leicestershire LINk. Geoffrey Smith wrote in his e-mail:

“The experience of Local Involvement Networks in securing adequate funding for their work from the grants made to local authorities by the Department of Health does not inspire confidence that there will be adequate funding for the greatly extended functions given to Local HealthWatch.”

As I am sure hon. Members know, local healthwatch will bring together LINks, patient advocacy and liaison services, and complaints services in one body.

Mr Smith continued:

“Without such funding there will be no consistent Local HealthWatch service, the public will be confused and the reputation of HealthWatch will be irreparably damaged.”
Karl Turner: Is my hon. Friend concerned, as I am, about ring-fencing? If local healthwatch is to rely on the local authority for its funding, surely there is a major concern about those budgets being ring-fenced.

Liz Kendall: My hon. Friend makes the point that I was about to come on to. National Voices—the national organisation that gives a voice to patients and the public—said that the simple answer is to protect local healthwatch funding, which it says is being cut due to pressures on local authorities. Ring-fencing is the best way to enable an effective local champion. It is pretty simple; I do not know whether the Minister has discussed that matter with his right hon. Friend. Friend the Secretary of State for Communities and Local Government, but it is something he should look at, and we would support it.

Interesting evidence was provided to the Committee by the National Association of LINks Members, showing that local authorities have already cut funding to LINks, which is entirely understandable, because they have to keep funding for child protection and care for older people. The evidence showed that local authorities have cut funding to LINks by an average of 24%, so a quarter of their budgets have been cut. Some councils have cut funding for LINks by up to 76%. I say to Government Members, including my relatively close neighbour, the hon. Member for Loughborough, that if they want to back that patient and public voice, which I believe the hon. Lady wants to champion, LINks should be independent and they should not have their budgets cut by a quarter. Those are the concerns we have on this area of the Bill.

Fiona O’Donnell: Thank you, Mr Gale, for giving me another opportunity to speak in this part of our debate. I would also like to thank my hon. Friend the Member for Kingston upon Hull East was particularly interesting.

There is a question about the funding of local healthwatch organisations, and my concerns go beyond ring-fencing and the need to protect budgets. In responding to the previous clause, the Minister seemed to adopt a passive rather than proactive approach to the duties that would be expected of local healthwatch organisations. I absolutely want them to be able to respond, develop and emerge to reflect local need, but I think we also need an assurance about the quality of services and access to them over different local authority areas. My concern is that when budgets are tight, advertising and training, for example, are the first things that are cut, even though they are essential to the quality of services that healthwatch organisations will deliver locally. Will the Minister give us assurances about how we will know that those organisations will genuinely reflect local views? How will that be measured? How will the local community be able to intervene if it thinks that its local healthwatch organisation does not reflect its views and is not acting in its best interests?

On independence from local authorities, the submission by the National Association of LINks Members says: “Healthwatch can’t be both the champion of the public and the poodle of the local authority.”

We need reassurance that there will not be a conflict in that area, because we can imagine several scenarios in which that could become an issue. There are lessons to be learned from Southern Cross, and my experience locally has been that the local authority, struggling to find places for people with special needs and learning disabilities, is accessing services that I would certainly not be happy for my mother, or my son or daughter, to use. If it is not good enough for my family, it is not good enough for anyone’s.

I was not satisfied with the Minister’s response about the provision of advocacy services. It is important that such services are provided at a local level, because they will be far more effective as a result of the local knowledge that has built up. I hope that the Minister will at least provide some guidance to local healthwatch organisations to encourage them to use local mental health advocacy services and carers’ organisations, so that we can be sure that there is a known standard in health care organisations.

I am sure that we have met people in our surgeries and on our visits who complain about the service that is provided, but when we approach the local authority, we are told, “Well, they have told us that everything is fine.” It is often difficult for older or vulnerable people to speak up and complain about the service when someone from the same organisation will be delivering very intimate care to them the next day.

Will the Minister give us some information about which groups will have a duty to provide information to local healthwatch organisations? I am struggling to keep count of all the organisations and quangos that are being created by the Bill, but there are concerns that clinical commissioning groups may not have to provide information. Can the Minister give me any assurances about that?

Dr Poulter: I note what the hon. Lady has said about quangos, but are we not in danger of having unaccountable bodies in the LINk organisations that are accountable only to themselves on a local level? They may purport to represent the interests of patients—in many cases, they may well do that—but in some cases they may be pursuing the agendas of a very few people in an area, which are not necessarily for the general benefit. Having a link with the local authority helps to provide better joined-up thinking, greater accountability and a better voice for patients because of the larger agenda that the local authorities are engaged in for health.

Fiona O’Donnell: I cannot provide the hon. Gentleman with that reassurance, but I am seeking it from the Minister. It is the Minister who has to answer these questions. That is why I asked whether local healthwatch organisations would deliver true accountability and reflect the views of local communities. The hon. Gentleman’s intervention would be better made to the Minister.

Emily Thornberry: I know that my hon. Friend did not have the benefit of being a member of the original Bill Committee, but at that stage, the point was made that it would have been good for the Government to evaluate LINks before abolishing them and introducing something else. Does my hon. Friend know whether in the interim period, as part of their listening exercise and pause, the Government have finally looked at the effectiveness of LINks and found out whether there are any lessons to be learned?

Fiona O’Donnell: I confess that I am not aware of that. I wish that I had asked Professor Field whether the Future Forum took that into account, but hopefully the
Minister will take the opportunity to answer where I have failed. Finally, reflecting on my earlier observation, I would like the Minister to tell us whether local healthwatch organisations will have any influence on the commissioning of services used by local authorities.

Paul Burstow: Before I address the points raised by Opposition Members, I want to correct a term of art related to the shadow bodies that are being established. I used the term “early implementers” when talking about local healthwatch when I should have used the phrase “pathfinders”, and in future I shall refer to local healthwatch as such. The pathfinders are an important part of ensuring that we draw lessons about good practice from LINks into the new system and that we build on good practice elsewhere when involving patients in the work of local healthwatch.

The hon. Member for East Lothian asked about raising the profile of local healthwatch. It is not all about advertising! As I have said, we have a development programme in place. Our advisory group, which is made up of stakeholders from LINks, local authorities, voluntary groups and community groups, is working through the way in which the profile of local healthwatch can be raised at local level. The communications working group is looking at developing a toolkit of materials to help patients understand how and where to access local healthwatch from October 2012. We hope to benefit from earlier implementation with the pathfinder programme.

I made a sedentary remark during the comments of the hon. Member for Leicester West, which is uncharacteristic for this Committee, and I apologise unreservedly for doing so. I reacted in that way because I was casting my mind back to the debates on the role of the Commission for Patient and Public Involvement in Health. I recall that many people involved in local patients forums at the time felt that the organisation they often called “Chippy” was overweening and overbearing in the exercise of its functions, not least in its distribution of resources, so I had a feeling of déjà vu. It is interesting that those organisations now feel the opposite.

My noble Friend Earl Howe and I are happy to continue engaging with the National Association of LINks Members on such issues, but I remind LINks members, some of whom were involved in previous iterations, of their concerns about being told what to do by national organisations. Learning may be necessary on all sides when it comes to such issues.

The hon. Member for Leicester West suggested that local healthwatch will be part of the local authority. It most certainly will not. Local healthwatch organisations will be separate bodies, and we are providing for their establishment as bodies corporate. They will have a variety of legal identities, including as social enterprises, so legal independence will be established.

It is important to reassure Opposition Members on that independence by rehearsing some of the issues. A local healthwatch organisation will set its priorities based on information and intelligence gathered on local health and social care. Although some requirements will be imposed on it, a local healthwatch organisation will, in general, choose independently how to deliver its work, which is further reinforced by its place on the local health and well-being board. The local healthwatch organisation has a separate status in shaping local health decision making.

Additionally, local healthwatch organisations have independence because they feed up to HealthWatch England. Local authorities cannot unilaterally veto the plans of local healthwatch. They cannot stop a local healthwatch giving advice, including advice to local authorities, and they cannot abolish it without the Secretary of State’s consent. Not only are there local safeguards, such organisations have clear independence.

Emily Thornberry: Is it correct to say that the funding of local healthwatch is not ring-fenced? Local authorities, although they may not abolish local healthwatch organisations, could, to coin a phrase, simply strangle them at birth.

Paul Burstow: No. I will explain why the hon. Lady is second-guessing my remarks, but first I shall say something on funding.

We are making available £60 million to fund local healthwatch. It is for local authorities to make the funding available through local determination, and we are working with local authorities through our healthwatch advisory group and the pathfinders. We recognise the importance of making the funding available to local healthwatches in full, which is similar to what we are doing in other areas. We do not think it would be right to ring-fence local healthwatch money. The NHS Future Forum agreed with that view and said that it was not appropriate for central Government to ring-fence funds in that way.

We are aware of the concerns of the National Association of LINks Members and of its report this year on funding cuts to local involvement networks, which says that the cuts are causing difficulties to LINks as a result of the problems that local authorities face. We want to ensure that we raise the profile of HealthWatch and the importance of its role from 2012. The funding that local healthwatches receive will ensure that the voices of patients, service users and the public are not lost during the changes. That brings me to why I disagree with the assertion that the hon. Lady made.

Local authorities will have a duty to seek to secure local healthwatch arrangements that operate effectively. Local authorities will also have a duty to make those local healthwatch arrangements, which inevitably means providing the necessary funds to enable those activities to take place. The hon. Member for East Lothian said that a local healthwatch should be a champion, not a poodle. That is certainly the Government’s intention, which is why we have established checks and balances.

Interestingly, the hon. Lady then posed an important question, and asked what do we do when a wayward healthwatch is not representative of its population and does not properly take concerns into account? That is the question, not where there is a legitimate role for a democratically elected and accountable local authority to step in and make an appropriate challenge. It is one of the checks and balances that we are trying to construct with the Bill, which is why we have a pathfinder programme to ensure that we get it right as we implement the changes. With that, I propose that the clause stand part of the Bill.

Question put and agreed to.

Clause 179, as amended, accordingly ordered to stand part of the Bill.
Paul Burstow: I beg to move amendment 231, in schedule 15, page 363, line 10, at end insert—

“(3) The regulations must make provision requiring a person who has power to appoint a member of an LHW to act with a view to securing that the members of the LHW (taken together) are representative of—

(a) people who live in the LHW’s area,
(b) people to whom care services are being or may be provided in that area, and
(c) people from that area to whom care services are being provided in any place.

(4) In sub-paragraph (3), “care services” has the meaning given in section 221.

The Chair: With this it will be convenient to discuss Government amendment 232.

Paul Burstow: Amendment 231 requires regulations on local healthwatch membership to include a provision that places a duty on the person appointing members to act with a view to securing those who are representative of the local healthwatch area—an issue that we have discussed in an earlier clause stand part debate.

Amendment 232 requires local healthwatches, when making arrangements for certain persons for the exercise of their functions or for assistance in exercising their functions, to act with a view to ensuring, in as far as it is appropriate, that those persons taken together are representative of the area. In essence, these amendments are trying to address something that we were told about during the listening exercise and that the NHS Future Forum said that we needed to address, which is how we ensure that this organisation represents the breadth of views within the local community and the diverse characteristics that make up a community—whether it be carers, young people or otherwise.

Emily Thornberry: I listened with interest to what the Minister said in relation to this amendment. I ask anyone reading Hansard to read it in conjunction with the arguments that we put forward at an earlier stage in relation to patient and public involvement in HealthWatch. It is not sufficient for there to be people who are self-representative of a local community. There needs to be much more active outreach in terms of speaking to the public. Frankly, this is a job that should not be left to chance. There should be proper expertise. Rather than go through all the arguments that we rehearsed at an earlier stage in relation to patient and public involvement in HealthWatch. There needs to be much more active outreach in terms of speaking to the public. Frankly, this is a job that should not be left to chance. There should be proper expertise. Rather than go through all the arguments that we put forward at an earlier stage in relation to patient and public involvement in HealthWatch.

Paul Burstow: I beg to move amendment 230, in schedule 15, page 364, line 17, at end insert—

“(5) In making arrangements under this paragraph, an LHW must act with a view to securing that, so far as appropriate, the persons with whom it makes the arrangements (taken together) are representative of—

(a) people who live in the LHW’s area,
(b) people to whom care services are being or may be provided in that area, and
(c) people from that area to whom care services are being provided in any place.

(6) In sub-paragraph (5), “care services” has the meaning given in section 221.

Paul Burstow: I beg to move amendment 204, in schedule 15, page 364, line 17, at end insert—

“(5) In making arrangements under this paragraph, an LHW must act with a view to securing that, so far as appropriate, the persons with whom it makes the arrangements (taken together) are representative of—

(a) people who live in the LHW’s area,
(b) people to whom care services are being or may be provided in that area, and
(c) people from that area to whom care services are being provided in any place.

Paul Burstow: I beg to move amendment 204, in schedule 15, page 364, line 17, at end insert—

(3A) A person to whom views are made known or reports or recommendations are made under subsection (2)(d) must, in exercising any function relating to care services, have regard to the views, reports or recommendations.

The amendment will create a duty on those responsible for commissioning, providing, managing or scrutinising local care services and on HealthWatch England to have regard to the views, reports and recommendations from local healthwatch organisations when exercising functions relating to care services. The NHS Future Forum’s patient involvement and public accountability report was generally supportive of the Government’s proposals for HealthWatch, describing it as a “new powerful consumer advocate at local and national level”.

However, the forum also reported concerns about the extent to which local health and social care bodies would voluntarily pay heed to the outputs from local healthwatch organisations, an issue we have recently discussed. The forum said,

“It cannot be assumed that just because local healthwatch exists in its role as a consumer champion and to provide scrutiny and challenge, that commissioners and providers will be receptive to it looking into areas of concern and take notice of any findings.”

The NHS Future Forum took the view that the way to deal with those concerns was to place a duty on commissioners and providers to have regard to the findings of local healthwatch organisations, and recommended accordingly. That is what the amendments do.

I can assure hon. Members that the duty applies in relation to both health and social care service functions for the people receiving those services. The amendment refers to “care services”, and adds a new subsection to section 221 of the Local Government and Public Involvement in Health Act 2007. Section 221 defines “care services” as services provided as part of the health service in England, or services provided as part of the...
social services functions of a local authority. On that basis, I hope that hon. Members will accept the amendment as a way to ensure greater patient involvement.

Emily Thornberry: To a certain extent, the amendment illustrates the Government’s lack of understanding of how HealthWatch ought to be and function. If HealthWatch is truly representative of a local area and patients, then any local authority would be foolhardy not to listen to it. That is why an important part of HealthWatch is how to ensure that it is properly representative. We believe that the Government have missed a golden opportunity to firm up legislation in relation to HealthWatch, such as the amendments and arguments we put forward earlier. Structure by itself is simply not enough. Proper public engagement is the key. We do not believe that the legislation as it is currently formulated does that sufficiently.

The Government feel that they can answer the legitimate concerns of the community about HealthWatch by simply saying that health and well-being boards must pay attention to what it says. The fact that we need that in legislation shows that the Government appreciate that people are not confident that HealthWatch will be sufficiently robust, independent or strong to fulfil the very important role that we all want it to have.

The Chair: I hate to say this, but the speech from the Front Bench did not relate to the amendment under discussion. We must try to concentrate on the amendments.

Tom Blenkinsop: I have a small question relating to the Government’s description of amendment 230, which says,

“The amendment does not create a duty on any of these persons directly to act on any views, recommendations or reports from local healthwatch, but does mean that they will need to be able to demonstrate that proper consideration has been given to them in exercising functions relating to care services.”

What would demonstrate proper consideration? Having knowledge of negotiations and consultation with other bodies from an employment aspect, I might assume from reading this that writing, “We have paid proper consideration to your recommendations,” would suffice as proper consideration in a written format. Is there any explanation of what proper consideration would constitute? Would there be a system of demonstrating proper consideration? Apart from that, it is welcome, but I would like to check that one small aspect.

4 pm

With reference to previous clauses, I can see where the Government are coming from in attempting to give HealthWatch more recognition, but clauses 71 and 72, by their very nature, limit HealthWatch’s ability to have any input in the process. From an employment background, this is just like any other works committee, which is a patsy, rather than a genuine, recognised body that can have genuine input and table genuine recommendations.

Paul Burstow: The hon. Gentleman gets the prize for being able to bring mergers and acquisitions back into the discussion by referencing clauses 71 and 72. I congratulate him on his perspicacity. Let us return to the clause in front of us and what the amendment is about, which is how we ensure in one way—it is not exclusive—that the work of local healthwatches is seen as important in the local system. That goes back to the point that was made by Jeremy Taylor when we received evidence at the start of the Committee stage, which is that the legislation and the amendments are certainly essential, but they are not sufficient. That is why we have a pathfinder programme, and that is why we have a collaborative process to roll out both HealthWatch England and local healthwatch. We are working with existing stakeholders from LINks, with local authority colleagues and with all those who have an interest in getting right the design of this important vehicle for delivering patient voices into the system. It cannot, as the hon. Member for Islington South and Finsbury quite rightly said, simply be a matter for legislation. It must be about attitudes and culture. We have quite a lot of work to do to undo the damage that has been done by the constant changes that occurred over the past 13 years.

I therefore hope that, with the changes and amendments, we can secure a patient involvement mechanism, through HealthWatch and local healthwatch, that is effective at delivering what patients and carers need.

Amendment 230 agreed to.

Clause 180, as amended, ordered to stand part of the Bill.

Clause 189

Joint Strategic Needs Assessments

Paul Burstow: I beg to move amendment 206, in clause 189, page 170, line 23, after ‘(8)’, insert ‘—

(a)’.

The Chair: With this it will be convenient to discuss Government amendments 207 to 210.

Paul Burstow: It is important that we look back to previous deliberations of the Committee when discussing the interpretation of phrases such as “have regard to”. I urge hon. Members to refer to the deliberations of the previous Committee stage on 17 February 2011, Official Report, column 274, for the answer that the hon. Member for Middlesbrough South and East Cleveland was seeking.

The Future Forum has said that if the “Government’s proposed change to the NHS—putting the patient first—is to be made a reality, the system that emerges must be grounded in systematic patient involvement.”

We absolutely agree with that, and the amendments ensure that that happens. As the committee will know, local authorities and clinical commissioning groups must discharge their duty to assess the needs of the community and prepare a joint health and well-being strategy through the health and well-being board. There is no current requirement in the Bill for health and well-being boards to involve the public and patients in preparing joint strategic needs assessments or joint health and well-being strategies. The amendments would put that right. Many in local authorities might say that they would have done that anyway, but we heard the concerns that were expressed during the listening process, and we wanted to ensure that they were clearly addressed,
so that no local authority could set its face against properly involving the public in working up joint strategic needs assessments and in developing health and well-being strategies. That is the purpose behind this group of amendments.

Amendment 209 will impose a duty on local authorities and clinical commissioning groups, and, through them, health and well-being boards, to have regard to statutory guidance when preparing such strategies. It is important to say that, in preparing that statutory guidance, which we have already started work on, it is our intention to see it as a co-production. We are working very closely with the Local Government Group and a variety of other stakeholders to ensure that we have good guidance around the production of joint strategic needs assessments and joint health and well-being strategies. That production should feel commonly owned by all who have a stake in the workings of this part of the new system.

Amendment 206 agreed to.

Amendment made: 207, in clause 189, page 170, line 24, at end insert ‘,’ and (b) after paragraph (b) (but before the “and” immediately following it) insert—

“(ba) involve the Local Healthwatch Organisation for the area of the responsible local authority;

(bb) involve the people who live or work in that area;”.

(c) in paragraph (c) for “consult” substitute “involve”.—(Paul Burstow.)

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

Emily Thornberry: The amendments tabled include some that are minor drafting amendments, but others that are not. In particular, amendment 207 adds to section 116 of the Local Government and Public Involvement in Health Act 2007 a responsibility on local authorities and commissioning consortia to “involve” rather than merely “consult” local healthwatch organisations and people. One wonders why we had such a battle over this; it seems such a basic point. While we are pleased to see it as a co-production, we are working very closely with the Local Government Group and a variety of other stakeholders to ensure that we have good guidance around the production of joint strategic needs assessments and joint health and well-being strategies. That production should feel commonly owned by all who have a stake in the workings of this part of the new system.

Amendment 209 makes it clear that, in preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must—

(1) In preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must—

(a) involve the Local Healthwatch Organisation for the area of the responsible local authority, and

(b) involve the people who live or work in that area.‘.

Amendment 210, in clause 190, page 171, line 19, at end insert—

‘(c) in preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must—

(a) involve the Local Healthwatch Organisation for the area of the responsible local authority, and

(b) involve the people who live or work in that area.’.

—(Paul Burstow.)

Paul Burstow: I beg to move amendment 211, in clause 190, page 171, line 36, leave out ‘relevant’.

The Chair: With this it will be convenient to discuss Government amendments 212 to 217.

Paul Burstow: These amendments are minor and technical in nature. They amend the provisions governing which joint strategic needs assessments and joint health and well-being strategies the local authority, the NHS commissioning board and clinical commissioning groups must have regard to. This is a point on which the provision in the original Bill was too narrowly drawn, as it required commissioners to have regard only to the most recent assessment and strategy, whereas there might be other assessments and strategies that were also relevant if they were specialist, covering particular areas rather than every aspect.

The amendments accordingly require commissioners to have regard to any joint strategic needs assessments and joint health and well-being strategies relevant to the exercise of their functions. For example, as part of a locality’s planning cycle, the JSNA and health and well-being strategy may have to be prepared several months in advance. There might, therefore, be a period during which the most recent joint strategic needs assessment and joint health and well-being strategy are not the relevant ones for the purposes of the current commissioning plan. We are trying to make that clear with these minor technical changes.

Emily Thornberry: Clause 190 deals with joint health and well-being strategies, and the amendments seek to prevent local authorities and their partner commissioning
groups from cherry-picking the functions that they choose to focus on, on the basis of their determining which functions are relevant. We think that that is important. The responsibilities of local authorities and consortia are redrafted and widened so that they have regard to joint strategic needs assessments and joint health and well-being strategies, but the amendments do not go far enough.

The debate on this issue has been about the connection between health and well-being boards and the commissioning consortia. Does the Minister really think that the proposed changes amount to making, as called for by the Future Forum, health and well-being boards the focal point for decision making about health and well-being? The Future Forum recommended that health and well-being boards should agree clinical commissioning consortia plans, but the amendments require consortia to involve the boards at all stages and to refer back to the commissioning consortia, or upwards to the NHS commissioning board. That is not the sign-off that we expected, and the Local Government Group shares our concerns. It has said that

“This falls short of the power of sign-off and in the LG Group’s opinion, this is not sufficient to ensure that commissioning plans are firmly based on the health and wellbeing needs and priorities of the local community.”

The Minister might remember the Secretary of State at one stage saying that the original Bill—before the pause and the amendments—would give health and well-being boards the ability to sign off commissioning consortia’s plans. It has never said that. It did not say that before it was amended, or before the pause, and it certainly does not say that now. That is what the Future Forum wanted, and that is what we called for, so the plans still do not go far enough.

Perhaps the Minister will again reject these concerns, as he did during the previous Committee, as being “inflated and exaggerated”, but perhaps he would also like to answer some questions. If the health and well-being board does have any power, it seems to be to complain to the national commissioning board. What is that about? What will it mean? Perhaps the Minister could help us with that. What evaluation have the Government made of the relationship between pathfinder commissioning consortia and the health and well-being boards? How is that working, and will he publish that information?

If the health and well-being boards are to be responsible for assessing the health needs of their population in the joint strategic needs assessment and for writing a plan to deal with those needs in the health and well-being strategy, they should have a decisive say in how that plan is to be enacted. They should not be toothless. It is a matter of great concern, not just to us but to many organisations, that the health and well-being boards, despite the spin, still have no teeth. During this recommittal of the Bill we tabled an amendment, which I believe was not selected. We would have liked to mandate the relevant health and well-being board to have the power to sign off the consortium’s commissioning plan, but because we were given inadequate time to consider the Bill, we have not been able to debate that issue.

Mr Burns: That is not true.

Emily Thornberry: It is.

Mr Burns: It is not.
The power of health and well-being boards hardly jump out at one from this paper, and this, I would suggest, is the attitude likely to be displayed by the NHS commissioning board. Given that the evidence here is of one set of attitudes, would it not be a good idea to do a little more than trust the attitude—possibly of David Nicholson, or whoever is going to be dealing with it—to listen to health and well-being boards when they are grasping up local commissioning consortia? Might it be that the health and well-being boards will complain to the national commissioning board, be patted on the head, told, “There, there dear”, and ignored? Health and well-being boards will have no power to deal with this at all. [Interruption.]

There is a certain amount of huffing and puffing going on from the Government Benches, but I am afraid that the point I make is a serious one. Perhaps I should not use such frivolous language. It has been a long few weeks. However, the point I am making is a powerful one and deserves to be addressed, and addressed properly, remembering in particular the views of the Future Forum report, and the legitimate concerns that have been raised everywhere. We, on this side, may talk about driving competition into the heart of the NHS. If the democracy is health and well-being boards will have no control over commissioning consortia other than an ability to complain to the national commissioning board, which will ignore them, what is the power that we really have?

The Chair: Order. The hon. Lady has clearly faced the same difficulty as I faced myself—the amendments, which is what we are discussing, are narrow and technical. She has happily engaged in a stand part debate. I am content with that on the understanding that there will not be a further stand part debate. That is it.

John Pugh: I am extremely glad. The tone of the hon. Member for Islington South and Finsbury slightly mystifies me. Somewhat synthetic anger is being presented here. Many of us can remember the 13 years of the Labour Government when there was a clearly identifiable democratic deficit in the NHS—[Interruption.]

The Chair: Order.

John Pugh: I was elected at the same time as Dr Richard Taylor. He was elected off the back of a huge local protest about a particular commissioning decision in his area. Dr Taylor was a very distinguished Member and he did a great deal during his time to lobby for greater accountability—the kind of accountability that got him elected. He wished to be accountable in some shape or form for the local health service.

Emily Thornberry: Is not the hon. Gentleman as concerned as I am that the one strong power that overview and scrutiny committees had was to refer reconfigurations to the Secretary of State, and that that will be taken away by the Bill?

John Pugh: I think the hon. Lady is wrong. For new Members, this has been a running sore through Parliament. For the decade that I have been here, various all-party groups have been set up to deal with inadequate democratic accountability. There have been community hospital group campaigners, small hospital group campaigners and so on. We are confronted with the persistent reluctance of Government to empower the democratic voice. It is not just Government. If one spoke to the people at the NHS Confederation in years gone by and mentioned the prospect of local councils having any input into local commissioning decisions they would blanch. They did not like the idea at all; they were far more comfortable with the model they had at the time.

To be fair, there are some quite rational considerations behind their nervousness on this issue. Dr Taylor gave me a good example of where this dilemma occurs. If populism is given full rein, it can sometimes trump clinical safety. It seems to be an empirical fact—people will correct me if it is wrong—that maternity units with fewer than 2,000 live births are not as safe as those with more.

Dr Poulter: As a general point, that is probably a fair comment, but there are a number of smaller units in this country with fewer than 2,000 live births and very good safety records. His general point is true, but a lot
of practices have come into force that support evidence that smaller birthing units are becoming just as effective and safe.

**John Pugh:** The example was given to me by Dr Richard Taylor, who was emphatic that we needed more democratic accountability in the system and could see the problem that, at some point, the popular voice could conflict with the expert voice. Equally, another fear is frequently raised by people who are campaigning to retain services. They fear that sometimes financial expediency and institutional interest can be disguised as clinical safety. I had a discussion with the Secretary of State the other day on precisely that point. He agreed with me that this was often part and parcel of many of the debates he had had over the years about unpopular configurations.

There is a general perception that if you allow councillors too great an input, they will decide things for which they are not financially accountable—or, worse still, get involved in the micro-management of the service. So there is a real issue here and I do not suppose it is an easy one. There is a general in-principle issue of having people make decisions when they are not directly accountable for all the consequences. However, at the end of the day, if councils and elected bodies have to live with the consequences, they will always be mindful of them. Contrary to what the medical world thinks, local councils often make very tough decisions simply because they know they have to be made. They do not invariably veer down the line of stupid populism, particularly if they have to live with the consequences.

Weighing all this up, in the last Parliament I produced a private Member’s Bill that I thought was a solution. Essentially, I suggested that there should be an annual commissioning plan, subject to ratification and possible amendment by a democratically elected body. Working on an Occam’s razor principle and not wanting to create institutions—I did not know at that stage of a health and well-being board—I thought we could usefully use the existing overview and scrutiny mechanism and co-opt what relevant people were necessary to make it work effectively.

I still think that that is a more elegant solution, but it is not where we are. That is the general dilemma. I say in all honesty to Labour Members that the more I look at this legislation, the more I think it makes it difficult for the clinical world to walk completely out of step with the community will. For a variety of reasons, which are mapped out in various parts of the legislation, I do not think that it could get to a situation where, as in Kidderminster, there could be a complete override and almost indifference to what the public see and what the experts, though not necessarily NHS experts, have to contribute.

If we look at the legislation—the Minister has yet to speak, and I am sure he will elaborate on this—we see that there is no absolute veto on the part of the health and well-being board. We have to think whether we would be comfortable in all circumstances with an absolute veto of clinicians if they give strong reasons for the particular route that they are going down. Equally, within the current architecture as I understand it, it is difficult for clinicians to proceed in wholesale indifference to what the public will is saying—apart from anything else, the plan to which they will be bound will essentially be a joint strategic needs assessment into which they will appear to have an input.

**Nick de Bois:** On clinicians making a decision, does the hon. Gentleman accept that the difference with this Bill is that they will make a local judgment, based on local strategic needs—not a judgment remotely imposed from afar?

**John Pugh:** That may well be true, but do not run away with the idea that even local clinicians do not at times have individual interests about things they want to do that the public might not wish them to do. An example is what I was talking about earlier, where I was blooded on this issue—when it was decided that children’s A and E would be taken out of Southport and put in Ormskirk.

The acute hospital did it, the PCT supported the commissioning decision and has done so persistently, despite having had several inquiries to try to establish precisely where the public voice is. In that particular case, it recognised that there was a problem of public will, but it refused to resolve it.

4.30 pm

Speaking to my local GPs recently, I have discovered that they refused to recognise the problem. We want to do away with the idea that there cannot be a conflict.

What we must do is ensure that we balance out factors such as clinical safety and the public’s legitimate demand to have fair access to the right sort of services in some sort of rational way. It is not easy.

If we had full-blooded local health boards, we would still have some kind of need to finesse them so that considerations of clinical safety were not over-ridden. It is a tricky area—one that is possibly capable of further tweaking and improvement. When we consider the legislation, we can see that we are a step beyond where we were in the previous Parliament.

**Emily Thornberry:** I am grateful to the hon. Gentleman for raising his points. For me, this goes to one of the essential parts of the Government. We have found ourselves in a situation in the national health service in which some £20 billion-worth of efficiency savings need to be made. For the past year, the NHS has effectively been at a standstill. When the NHS commissioning board, the commissioning consortia, HealthWatch and the health and well-being boards come into being, it may well be at a time when hard decisions need to be made. The example that always springs to the mind of the public is the reconfiguration of services. Who is going to make the decision that a hospital needs to close a ward, an A and E unit or a maternity unit? Who is to make the decision about Finsbury health centre in my constituency?

If I have spoken about the Finsbury health centre before, let me do so again as it had a strong impact on me. When the primary care trust wanted to close Finsbury health centre, I would go to see it, thump the table—I am sure that Members will not find that hard to recognise—and say, “Will you listen to me? I am the elected representative of Islington South and Finsbury. People do not want this health centre to close. What are you doing?” Again and again, I would attend these meetings, but feel that I was not being listened to.

The overview and scrutiny committee of the local authority was able to send that decision to the Secretary of State. When the primary care trust was “consulting”
over the closure of Finsbury health centre, it was not consulting over whether it should close, but on how it should close. We were able, through the reference to the Secretary of State, to send the proposal back—and Finsbury health centre remains.

What will happen now? Who will be making the hard decisions on issues such as Finsbury health centre? If the GP commissioning consortia have effectively taken over from primary care trusts, how will they be answerable? The Minister says that they will be answerable through the health and well-being boards. What power do the health and well-being boards have over the commissioning consortia? They have none. All they can do is complain to the national commissioning board, which may ignore them.

The Bill will take away the power of overview and scrutiny boards to refer to the Secretary of State—I would be so happy to hear otherwise or to hear that there had been an amendment to the Bill that I had missed that had brought back the power of the overview and scrutiny boards. I really do not think that there has, so that power has been taken away and what we are left is GP commissioning consortia and health and well-being boards without the powerful link between the two.

I appreciate that the changes being made may produce something that is better than the primary care trusts, but in terms of democratic accountability, it could not be a lot worse. After all the table-thumping meetings in the past in which I asked representatives of my primary care trust to listen to me, in my first meeting with them after the election of the Tory Government—whom the hon. Member for Southport supports—they said, “Save us.” It was difficult to be entirely sympathetic.

John Pugh: Does the hon. Lady accept this point? If a unit were part and parcel of delivering a joint needs assessment that had been agreed, and that was then referred to the national commissioning board—not as an ad hoc decision that was suddenly made and which did not fit with anything else—the commissioning board would be guilty of a dereliction of duty if it ignored such a thing. Is that not true?

Emily Thornberry: I accept that, and I may be emphasising certain things to ensure that my point is made. It could be that a joint strategic needs assessment is made and the implementation plan is agreed, but then the local elected councillors on the health and well-being board feel that the GP commissioning consortia’s interpretation of that plan is not the same as theirs. For example, they may say, “There is nothing wrong with closing the Whittington hospital, because there will be University College hospital instead, so it won’t be a problem.” My local authority, in representing the community, would have a great deal to say about that. In such circumstances, however, all it could do is refer the matter to the national commissioning board, which is a large, faceless quango with no democratic accountability. That is the problem.

Paul Burstow: It is not a problem because, as ever, the hon. Lady has misunderstood, or chosen to misunderstand, what the Bill provides for. The NHS commissioning board will be accountable to the Secretary of State through the mandate that he sets, as well as having direct accountability, through accounting officers, to many Committees of the House, not least the Select Committee on Public Accounts. The idea that there would be no accountability is extraordinary.

Let me talk about political accountability further, because Opposition Members have a new-found love of it that they did not seem to have when they were in government, which is refreshing. There is a balance to be struck between local accountability, which my hon. Friend the Member for Southport raised, and local accountability for a national health service—also an important part of this—as well as national accountability for the health service.

Several weeks ago, we debated key clauses at the beginning of the Bill, but I want to stress that the Secretary of State will set a mandate, which will be laid before Parliament, and it will be subject to consultation, as no similar document has been before. The NHS operating framework, which was the previous Administration’s tool of choice for directing the way in which the NHS operates, was never subject to consultation. There is a change in the strengthening of accountability.

The focus of all this is how we organise the NHS to deliver on outcomes. The NHS outcomes framework was the subject of extensive consultation last year, and of course—we have made it clear in the legislation—the organising principles of the NHS should be centred on quality and autonomy. When it comes to local accountability, we want to see local services and how they are organised genuinely fitting local circumstances and population need.

That is the role of the local health and well-being boards. It is about genuinely understanding and holding local organisations to account, by their being involved in the process to ensure that population needs are being met. That has been a weakness of the national health service with a top-down model, where it is directed from the centre. It has not been as effective as really understanding, engaging, and therefore meeting local needs and fitting those outcomes to local circumstances.

Dr Poulter: That is a key point because, at the moment, decisions are made about the reconfiguration of services; my hon. Friend the Member for Southport made the point about maternity services. Sometimes, and there is good evidence for this, smaller units may not be as safe as larger units, so there may need to be reconfiguration. Sometimes, however, there is good evidence that smaller units are effective and very safe. Through the mechanisms in the Bill, would not having that local scrutiny enable those decisions to be examined much more closely and more effectively for the benefit of patients?

Paul Burstow: In a moment, I will come to the issues of the checks and balances on reconfiguration decisions, because that may be for the edification of the hon. Member for Islington South and Finsbury. However, I want to address the specific point about there being a planning cycle, which includes joint strategic needs assessments, joint health and well-being strategies and commissioning plans.

In accepting the recommendations of the NHS Future Forum, we make it clear that a health and well-being board is an active participant in the whole cycle. It is engaged throughout. It is not only the recipient of a
finished product called “The commissioning plan”, which it can send to the NHS commissioning board if it does not like it, but it is engaged in its authorship—in many ways, if it co-produces it. It is not simply given the product to comment on at the end of the process; the process is ongoing. That fact has been completely lost on Opposition Members.

We return to the heart of the suggestion of the hon. Member for Islington South and Finsbury. I think that she has misunderstood, or perhaps slightly misrepresented, what the NHS Future Forum said. I will reread Hansard and I shall apologise if I am wrong. On strengthening the duties of health and well-being boards, the Future Forum said:

“We have concluded that…health and wellbeing boards are a vital part of the system that needs to be put in place. We heard different views on the issue of accountability to health and wellbeing boards: on the one hand many people have called for them to have sign-off powers over the annual commissioning plans which will be developed by commissioning consortia; others reason that this model of dual accountability will be confusing and unworkable.

We heard concerns that the Bill does not provide strong enough incentives for commissioning consortia to work together in cooperation with health and wellbeing boards and local authority commissioners in their planning and commissioning of health services.”

It makes three recommendations: first, “Health and wellbeing boards should agree commissioning consortia commissioning plans”. That is absolutely the case. They will be able to do that. Secondly, “If it is not possible to secure agreement locally on the plans, the health and wellbeing board should be able to refer their concerns to the NHS Commissioning Board.” Absolutely, and it is clearly the case. The NHS commissioning board must “have regard”, and as we have discussed, the legal status of “have regard” is more than an ephemeral thing that can be lightly tossed aside in the way that some speeches in the Committee can be.

The third and final recommendation is:

“The NHS Commissioning Board should take account of the views of health and wellbeing boards and the extent of joint working as part of their authorisation process and the ongoing assessment of commissioning consortia’s performance.”

That, too, is part and parcel of the approach in the Bill.

Owen Smith: As the Minister has in his hands the Future Forum’s report on health and well-being boards, will he remind the Committee of recommendation 16 on conflicts of interest and comment on the extent to which he is signally ignoring it?

Paul Burstow: No, because it is not part of this debate. Nice try. We started the debate on the word “relevant”, but it has spread to cover the whole clause. Conflicts of interest are important, but not part of this debate.

I return to the excellent evidence sessions at the beginning of the Committee on the re-committed Bill. When asked whether health and well-being boards should have power to veto commissioning plans, Councillor Barnard, representing the Local Government Association, said:

“I do not like the word ‘veto’. If you look at the way that health and well-being boards will work, I would like to base it on the experience of children’s trusts, for example—the idea that when you come together to commission services, if you start with the established health needs of the area, you have the joint strategic needs assessment, which will clearly set out the key determinants of health in the area. If you cannot come to an understanding and agree at that point—the health and well-being board and then look at the commissioning plans—if they don’t tie in, rather than veto something, you need to go back and review where you have got to.”—[Official Report, Health and Social Care Public Bill Committee, 26 June 2011, c. 38, Q87.]

That sort of iterative process is exactly what I have described in response to—

Emily Thornberry: Will the Minister give way?

Paul Burstow: I will in a moment, because I think it will be useful to pray in aid not only a Conservative member of the LGA, but the Association of North East Councils, which is probably a much broader coalition of local authorities. It is a political voice for local government in the north-east. In a submission to the Committee in July, it said:

“All of our member authorities are keen to take advantage of the opportunities offered by the Health and Social Care Bill to improve health outcomes for the people of the North East, working with our health partners. We are pleased to note that the Government’s proposed amendments to the Bill include a number of changes for which the Association has lobbied….the stronger role envisaged for Health and Wellbeing Boards with the clear expectation that commissioning plans will be in line with the Health and Wellbeing Strategy”.

That is what our amendments achieve. I give way one last time.

4.45 pm

Emily Thornberry: I am listening with interest to the Minister. He accepts that the Future Forum report stated:

“Health and wellbeing boards should agree commissioning consortia commissioning plans which should be developed in line with the joint health and wellbeing strategy.”

Is it in the Bill, therefore, that health and well-being boards should agree commissioning consortia commissioning plans? If so, will the Minister spell that out for me, because as I understand it, there is nothing in the Bill that says that they must agree? The point is this. If there is no agreement, how is that situation resolved? It is resolved only by the health and well-being board reporting them to the national commissioning board, which, as I have illustrated, is unlikely to be as sympathetic as one would hope, and might show old tendencies of the NHS.

Paul Burstow: The hon. Lady chooses to read out just the first of the three recommendations; I read out all three. All three need to be read in conjunction to understand the recommendations as a whole. The Government accepted all three recommendations. Two require legislation to give effect to them. One is that in dealing with the authorisation process and the assessment process, the NHS commissioning board will have to have regard to the opinions of the local health and well-being board. It is worth saying at this point that one of the other recommendations that has come out in the Government response is about recognising that these should be seen to be elected member-led bodies. They should have a majority of councillors on them in order to be seen as genuinely democratic bodies, leading on these issues at local level.
Paul Burstow: Yes, they will be able to make such referrals. I think that was three words. The hon. Lady asked for three words, which I gave, but for some reason that does not seem enough. I suspect there are not enough words in the history of time to reassure Opposition Members about the measures before the Committee. We understand that and the role that they seek to fulfil during consideration in Committee.

We have several more important clauses to scrutinise. Having set out clearly why these clauses should stand part of the Bill, I hope the Committee will allow them to do so.

Amendment 211 agreed to.

Amendments made: 212, in clause 190, page 171, line 37, leave out ‘the most recent’ and insert ‘any’.

Amendment 213, in clause 190, page 171, line 39, after ‘section 116’, insert ‘which is relevant to the exercise of the functions’.

Amendment 214, in clause 190, page 171, line 40, leave out ‘the most recent’ and insert ‘any’.

Amendment 215, in clause 190, page 171, line 41, after ‘section 116A’, insert ‘which is so relevant’.

Amendment 216, in clause 190, page 171, leave out lines 42 to 45.

Amendment 217, in clause 190, page 172, line 3, leave out from second ‘to’ to end of line 4 and insert ‘—

(a) any assessment of relevant needs prepared by the responsible local authority and each of its partner commissioning consortia under section 116 which is relevant to the exercise of the functions, and

(b) any joint health and wellbeing strategy prepared by them under section 116A which is so relevant.’.—

(Paul Burstow.)

Clause 190, as amended, ordered to stand part of the Bill.

Clause 191

ESTABLISHMENT OF HEALTH AND WELLBEING BOARDS

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

The Chair: There is cohesion between clauses 191, 192 and 193, and a lot of the ground covered by them has already been debated. I propose to take the three clauses as a stand part together, in expectation that they may probably already been discussed. If hon. Members wish to add anything, I shall allow that. They will be voted on separately but taken together.

Emily Thornberry: Clause 192 is potentially very important, with the duty to encourage integrated working. We can all agree that that is the holy grail. We must have more integrated working between health and social care: between primary and secondary care; between community services, doctors and local government.

On the one hand, the health service is relatively well funded, centrally driven and locally provided, with little democratic accountability. On the other hand, poorly resourced social care is locally provided, democratically accountable and means-tested. The difficulty has been to try to integrate the two, given how different they are. Although the clause is worthy, the real problem is
changing the nature of those two organisations. If we continue drastically to underfund social care, so that it becomes the Cinderella of the health service, we will never be able to achieve proper integration. There will simply be an unbalanced relationship.

There is huge concern that the social care system is currently underfunded by at least a £1 billion, and it is going to get worse next year and the year after. There is already huge strain on social care and there will be increased strain for the health service, as well. If the Government wish to integrate health and social care, they cannot cut social care to the bone, while at the same time cutting the health service, turning it upside down by the ankles and shaking it hard. Integrated working will not happen in those circumstances. The Government know it; we know it; everyone in the sector knows it.

The fundamental criticism of the Bill is that it misses the point. The challenge for all of us is to ensure that we get increased integrated working between health and social care. That is challenging and hard and needs a great deal of time and focus. Unfortunately, we have frittered that away on the Bill, which does not address social care. That is challenging and hard and needs a great deal of time and focus. Unfortunately, we have frittered that away on the Bill, which does not address that central problem.

Paul Burstow: I entirely refute the proposition that the past 12 months have been wasted. We have a Bill that has energised health and social care with the need to start talking to each other. I know from visits and other engagements that people are taking the opportunity afforded by the £150 million we are putting in this year to fund re-ablement services. The transfer of resources from the NHS to social care has led to more local dialogue between the NHS and social services than there has been for a very long time.

I suggest that, rather than lecturing us on investment in social care, the hon. Member for Islington South and Finsbury looks at the Committee’s debates. We will spend £2 billion extra by 2014-15 to secure the future of social care.

Question put and agreed to.
Clause 191 accordingly ordered to stand part of the Bill.
Clauses 192 and 193 ordered to stand part of the Bill.

4.56 pm
Sitting suspended for a Division in the House.

5.16 pm
On resuming—

Clause 242
Failure by NICE to discharge any of its functions

Paul Burstow: I beg to move amendment 218, in clause 242, page 216, line 37, after ‘that’, insert ‘—( )’.

The Chair: With this it will be convenient to discuss Government amendments 219 and 220.

Paul Burstow: The amendments deal with failure, which we talked about earlier in relation to the Secretary of State’s intervention powers. They make it clear that the Secretary of State has powers to intervene to exercise functions where there has been a significant failure.

Again, this is part of ensuring that the Secretary of State’s overarching duties concerning a comprehensive service, and his accountability to Parliament for delivering that, are secured.

Mr Barron: Mr Gale, would it be in order for us to discuss clause stand part at the same time, given that there is only one group of amendments?

The Chair: Yes, certainly.

Mr Barron: I am grateful for that, Mr Gale. I want to speak to the amendments, because they are important, and the Minister will be surprised to learn that I support them. They try to bring some clarity to a clause that, quite frankly, in the original Bill—I do not think that we had time to reach it—was a bit of a sword of Damocles, to say the least. The National Institute for Health and Clinical Excellence has been operating for more than 10 years. This clause is headed:

“Failure by NICE to discharge any of its functions”.

That is hardly a vote of confidence in an organisation that has been in existence for more than 10 years.

NICE will be given a lot more work under clause 231, which we have not debated this time around, which introduces quality standards. We were told at the first sitting of oral evidence for the original Bill—I think these figures are correct—that NICE had worked through some seven quality standards so far and there was an expectation that it would work through about 150 more, which would pass down to commissioning consortia and providers to be used for the commissioning and provision of national health services. At the time, I related that to Joseph Stalin, but the Secretary of State did not agree. The quality standards will certainly have cost implications, not only for NICE in the time that it takes to work through all 150 of them but for the national health service as a whole. Costs are an issue, as we have said.

It worries me that the clause as unamended is a bit draconian, to say the least, in what it could do to NICE, which has had a level of independence from politicians for some 10 years. It has not always worked properly, and I could give the Committee my views about that. At least Government amendment 220 ensures that the Secretary of State would have to be a little bit transparent about why he was taking action against NICE, in as much as he would have to publish his reasons for doing so. Government amendment 219 also clarifies in subsection (1)(b) that the Secretary of State may take action against NICE if it “is failing or has failed properly to discharge any of its functions” only if “the failure is significant.” The original wording was simply “to discharge any of its functions” and few institutions do that entirely to people’s satisfaction. I am pleased that the amendment now states that the failure must be significant. We could debate what that means, and perhaps the Minister will tell us in his reply exactly what is meant by significant.

One of the reasons why I wanted to speak is that during the previous Parliament I chaired the Health Committee. In 2007-08, we reported on the National
Institute for Health and Clinical Excellence, which was effectively nine years on rather than 10. One of the things we discovered was the issue of political interference with NICE. We took evidence, and two instances were brought to our attention regarding what was deemed political interference.

“During the inquiry witnesses expressed concern that health ministers had undermined the work of NICE. We were given two examples. The first involved the risk-sharing agreement established to allow NHS patients access to treatments for MS”, which some Members may remember.

“The second involved the breast cancer drug”—which I do not think I can pronounce—“trastuzumab”. Herceptin was its common name, so I think we will stick to that as that my Yorkshire accent can handle it a little better.

“NICE evaluated beta interferon and glatiramer acetate for MS in 2001. In 2002, it did not recommend the treatments as neither was judged to be cost-effective. A public outcry followed. Witnesses believed that as a result of the outcry the Department of Health sought a way to make the drug available despite the NICE recommendation. The Department came to an agreement with manufacturers of the drugs whereby the drug could be used in the NHS as part of a 10-year trial. It was agreed that if the drug was less effective than £36,000 per QALY, industry would recompense the NHS.”

We are now nearing the end of those 10 years. I have recently had correspondence from a pharmaceutical company that wants to chat to me about how it has worked out. The agreement said that the NHS would pay only if the treatment was effective with patients. There is still a big issue around that. The report did not endorse it at the time; we were quite sceptical and we were not sure whether, in the end event, barristers or clinicians would decide whether it was effective.

Liz Kendall: My right hon. Friend has raised a very important issue, because the model that is being used, where the drugs company shares the costs according to patients’ benefits, is the model upon which the Government wants to base the entire future funding of drugs. It is value-based pricing. Understanding whether that works in practice is absolutely critical.

Mr Barron: My hon. Friend is right; that is exactly what we are talking about. I do not want to be diverted, but when we were taking evidence in that particular inquiry, the Office of Fair Trading published a report and there were major issues. We will see what happens with the two horses the Government are going to ride. On the one hand we will have value-based pricing for new medicines, but on the other we will have the Pharmaceutical Price Regulation Scheme for others. I do not know how it will balance out, but we do not have time to debate it as it is not relevant to the clause.

Owen Smith: Does my right hon. Friend agree that another issue pertinent to the Bill, which we cannot discuss because the Government have not brought it forward, is what NICE’s role will be in respect of value-based pricing? Somebody must still determine the cost benefits of medicines. Indeed, somebody must negotiate with pharmaceutical companies over price; we assume that that will be NICE. Will that be one of the duties it will have to discharge in future?

The Chair: Order. The right hon. Gentleman knows what I am going to say. I know that he has huge expertise in this field and he is widely respected for it, but we really must concentrate on the clause. This is not an opportunity to discuss the whole past, present and future of NICE.

Mr Barron: I agree entirely, and I will not be diverted at all, but clause 242 has major implications for NICE and the work that it does. The clause does not focus only on quality standards; it is about NICE’s overall work. NICE is doing some brilliant work and has done so for many years.

Our second evidence session on political interference revealed the witness’s concern about the role of the then Secretary of State role in the availability of Herceptin. My hon. Friend the Member for Leicester West will know that, because the then Secretary of State was her predecessor in her constituency. In November 2005, North Stoke primary care trust reversed its earlier decision to refuse the drug to a patient with early-stage breast cancer after the then Secretary of State announced that she was “very concerned”. She called a meeting with PCT officials and asked them to consider assessing the receptor status of their patients on the assumption that if the drug became available it could be licensed quickly.

I remember that well. Herceptin had not been assessed by NICE, or licensed for use in early-stage breast cancer, but evidence of the drug’s efficacy for that type of cancer had been published on the manufacturer’s investor website. The patient had threatened to take the PCT to the High Court to contest its original decision not to allow her access to the drug, and shortly afterwards the Department asked NICE to examine the drug early. In evidence to the Select Committee, Professor Mike Richards, the national cancer director, said that that was “a political decision”. When Professor Rawlins of NICE gave evidence, he stated:

“The scientific basis for Herceptin being effective and safe in early cancer had not been demonstrated...Added to which, at that stage the company had not even made an approach to the regulatory authorities, it had not made an application, so it was a surprising remark from a Secretary of State.”

It was indeed.

On the day that that happened, there was a big rally by one of the big breast cancer charities in Westminster Hall, and I went over there. It was an effective lobby, and someone from south Yorkshire with early-stage breast cancer was there. I said that we will have to see how things develop, but the then Secretary of State moved on. Presumably she had been pleasing the crowd, but pleasing the crowd is sometimes dangerous, and that is what happened on that day. The consequence was that NICE felt that it had been the victim of political interference in its duty, which it believed was independent of politicians. It thought it was its duty to look at things in a proper way.

During that inquiry, we questioned the then Minister of State, my right hon. Friend the Member for Bristol South (Dawn Primarolo), who is now a Deputy Speaker, about political interference in NICE’s work. She said:

“I would absolutely stress that it is not the role for ministers to contradict, override or directly seek to influence a process where NICE are already engaged in consideration.”
She added:

“NICE’s final guidance will be final.”

We said:

“We note that it is not the role for Ministers to directly or indirectly seek to influence the NICE decision-making process.”

That is on the public record, and was published in reports at the time. The previous Government did not argue against it, which was embarrassing. There were two instances and in one there was certainly direct action by a Minister to destabilise NICE and to attack its independence. As we have not had the opportunity to discuss the clause earlier, that needs to be said, and I would like the Minister to respond, because even with the amendment, which I am happy to support, I would like to know exactly what role this and any other Government will have with regard to NICE when the Bill is enacted. NICE has done some brilliant work over the past 10 years, and it is a great pity for large parts of the national health service that, for whatever reason, quite a lot of what it says is not mandatory, so it is not implemented. It would have been better for the NHS and patients if it had been.

It seems that we are moving into an era in which quality standards issued by NICE will be the norm for commissioners and providers. In those circumstances, we must make sure that there will be no political interference for any reason if we are going to accept even this amended clause. I would be interested to see what the Minister has to say, because I genuinely believe that institutions like NICE are here for the good of patients in particular and its independence should be defended at all costs.

5.30 pm

Debbie Abrahams: I have a quick question for the Minister about the clause. In the previous Committee, we touched on the question of whether guidance is just that, or whether there will be more compulsion for practitioners and CCGs to accept it. Will it be considered a failure to discharge their functions if CCGs do not apply guidance, ignore it or make up their own? There is clear guidance about cataract surgery, for example, which is being ignored, because there is a need to stretch the money allocated to PCTs at the moment. Will there be more compulsion to follow guidance from NICE?

Paul Burstow: I shall answer that point first. The question we are debating in this clause is whether there is a significant failure by NICE. The hon. Lady’s question is about the way in which a clinical commissioning group behaves with regard to advice that it receives.

Debbie Abrahams: They do interrelate.

Paul Burstow: They do, but not through this clause. They interrelate through the function of the NHS commissioning board, which we discussed earlier. It is through both the authorisation and assessment processes, and the use of clinical guidance, that we have those mechanisms in place to deal with those particular concerns.

The right hon. Gentleman rehearses some powerful concerns about lessons that need to be drawn from past experiences. We have tried to incorporate those into the way in which, for the first time, we enshrine in statute the independence of NICE. It is worth reminding ourselves that at the moment NICE is a special health authority. It is not the fully independent entity that it will become as a result of the Bill being enacted. It is a special health authority that was created, if you like, at the whim of a Secretary of State and could simply be disposed of by a Secretary of State through a negative resolution. As a result of this Bill, it will require full parliamentary scrutiny and approval for any further changes of the sort that could have been undertaken so easily in the past.

It is also worth stressing that alongside the power to intervene where there is significant failure—I will come on to what “significant” means in a moment—there is a duty on the Secretary of State to operate in a way that maximises and facilitates autonomy in the system. We want to see that particularly in regard to bodies such as NICE. The right hon. Gentleman referred to Professor Mike Richards and his continuing role as the national clinical director for cancer services. I would like to take the opportunity today—not least because it is his birthday—to pay tribute to him for the work that he does and wish him many happy returns on his 60th birthday. I have not had a chance to put that on the record in any other way. He may not thank me for sharing his age with the Committee, however.

Owen Smith: He does not look it.

Paul Burstow: I agree. We were also asked about value-based pricing. That took the debate beyond the confines of the clause, but I want to share this information. The Government have been consulting on proposals on the new value-based approach to pricing branded medicines. We began the consultation in December, it closed on 17 March and we expect to publish our response shortly. There will be ample opportunity to study it and, hopefully, take it into account in our debates on Report.

I said that I would speak about the word “significant”. The courts have taken the approach of interpreting expressions using the term “significant” in the context of the underlying philosophy of the legislation in which the expression is used. There are a couple of cases where this has been explored. There is the Pedley case of 2009. There is also a quote from the case Re A (children) (care proceedings: threshold criteria) CA 2009. In essence, courts will look first at the definition in a dictionary, and they will then set that in the context of the Bill. In this case they will, I am sure, look at issues of autonomy as against the Secretary of State’s evidenced judgment about whether there has been a significant failure.

That means that if NICE does not recommend an important drug or recommends a drug that is controversial, the Secretary of State has no power to intervene. NICE is an independent body and must be allowed to issue guidance free from political interference. In making its recommendations, NICE takes into account all the latest clinical evidence and issues final guidance on the use of a drug only after careful consideration of that evidence and wide consultation with stakeholders. I hope that that reassures the right hon. Gentleman.

The right hon. Gentleman is right to rehearse the fact that there is a process in relation to quality standards. We say that there will be a library of up to 150, and the National Quality Board is working to commission those
from NICE. I hope that I have addressed the concerns of hon. Members and that the clause will stand part of the Bill.

Amendment 218 agreed to.

Amendments made: 219, in clause 242, page 216, line 39, at end insert ‘, and
(1) the failure is significant.’.

Amendment 220, in clause 242, page 217, line 8, at end insert—
‘(2) Where the Secretary of State exercises a power under subsection (1) or (3), the Secretary of State must publish reasons for doing so.—[Paul Burstow.]’

Clause 242, as amended, ordered to stand part of the Bill.

Clause 265

Failure by Information Centre to discharge any of its functions

Paul Burstow: I beg to move amendment 221, in clause 265, page 228, line 25, after ‘that’, insert ‘—
(1)’.

The Chair: With this it will be convenient to discuss Government amendments 222 and 223.

Paul Burstow: This group of amendments is a further repetition of the debate that we have just had about ensuring that the Secretary of State has the necessary powers of intervention where there has been a significant failure, in order to ensure that he can discharge his overarching duties to secure a comprehensive health service.

Amendment 221 agreed to.

Amendments made: 222, in clause 265, page 228, line 27, at end insert ‘, and
(1) the failure is significant.’.

223, in clause 265, page 228, line 35, at end insert—
‘(2) Where the Secretary of State exercises a power under subsection (1) or (3), the Secretary of State must publish reasons for doing so.—[Paul Burstow.]’

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

Grahame M. Morris: The Minister says that we are rehearsing arguments in respect of the powers of the Secretary of State, but there are some specific issues about the information centre to which clause 265 and the amendments that we have just agreed relate. I would like further clarification. For the information of the Committee, clause 265 deals with failure by the information centre to discharge any of its functions. It gives the Secretary of State powers to direct the information centre to discharge those functions himself, or to make alternative arrangements for another body to carry out those functions.
the failure regime for NHS foundation trusts will be tabled in another place. However, I have some questions about the clause and the amendments that we have just accepted. As I understand them, the amendments have placed two additional safeguards on the ability of the Secretary of State to intervene.

First—perhaps the Minister can correct me if I misunderstand the intent—the Secretary of State can intervene only where a significant failure has occurred, and he must provide a reason for doing so. While I welcome the intention of the clause and the amendments, that seems rather superficial, because the Secretary of State chooses whether to intervene or not, and without any checks or balances elsewhere. Therefore, the effect of the amendments may well be negligible in practice.

5.45 pm

In this clause, we are looking at the remedy for any failure at the NHS Information Centre, so it must be relevant to look at what types of failure are likely to provoke the Secretary of State into acting. I seek assurance from Ministers that support will be in place to ensure that the Information Centre can meet its objectives from the outset. We have raised the spectre of the Trojan horses of privatisation, and I would hate the measure to be used as such to outsource the functions of the Information Centre.

I will outline a potential failure scenario. This is an ambitious and welcome project, but without proper funding it is likely either to fail in meeting its objectives or to fail overall. In those circumstances, it would be duplicitious for the Secretary of State to take action to fix a problem that was essentially of his own making as a result of not making sufficient funding available.

Will the Minister assure us that proper, independently determined funding will be laid out as soon as is practicable? There are concerns about whether funding will be available to bring about the necessary change and to fulfil the Government’s aspirations. It is an ambitious proposal and the plans would be massively challenging at any time, and they are likely to entail substantial costs. Will the Minister comment on whether he sees institutional failure as something that the Secretary of State would be better placed to take responsibility for, rather than using the powers given in clause 265?

Can we have more detail on how the Minister foresees patients gaining greater access to their records and how quickly that will be achieved? Will he, for example, be setting out red lines for the time for accomplishing that? If those milestones are not achieved, will that be grounds for invoking the powers in the clause?

A briefing note was provided by the House of Commons Library, and it refers to the Health and Social Care Information Centre as a special health authority, as the Minister has outlined. The note states that the Information Centre will be set up as

“a non-departmental public body. In its role collecting data to support central bodies in discharging their statutory functions, it will have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board…”—

we now know that that will be called NHS England—

“The HSCIC will also be able to consider additional requests from other arm’s-length bodies, and carry out those data collections if specific criteria are met.”

It would be useful if the Minister clarified exactly what that meant. The briefing continues:

“It will have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this.”

Those are important duties, and the Opposition accept that research and information plays a fundamental role in effective health care.

This year has already seen funding cuts to the NHS Information Centre, which is separate from the new body and carries out important research for the NHS. It has had to reduce spending on surveys, which often form the basis of health care planning. The general lifestyle survey, for example, carried out every year by the Office for National Statistics on behalf of Government Departments, has, according to my information, had its funding withdrawn by the NHS Information Centre.

The survey provides statistics on public health issues that are particularly dear to the hearts of many Opposition Members. It provides important information, figures, and statistics that allow health policy to be developed and assessed, and it makes possible comparisons between one area and another.

Mr Baron: My hon. Friend makes an important point. The general lifestyle survey is one of the things that have enabled us to track the use of alcohol, and other such things, over many years and to form good public policy on that basis. Given that public health threats in the 21st century are more likely to be caused by lifestyle than by bad sanitation or lack of fresh water supplies, it is a foolish thing to do. Does my hon. Friend wish to comment on that?

Grahame M. Morris: That is a good point well made. Irrespective of which side of the Committee we sit on, we all want a full and accurate evidence base on which to plan effective health interventions. The general lifestyle survey is an important element of that. Given that information is key to patient choice, it does not augur well when the NHS Information Centre is being cut back. I invite the Minister’s view on that.

I am sure that the Committee will be relieved to hear that I will conclude my remarks in a moment. This clause addresses the possibility of failure in the new HSCIC, for which, to be fair, the Minister has grand hopes. We are right to be concerned about the Government’s direction of travel, because this year they have cut support for information and transparency in the NHS, not least on the patient satisfaction surveys.

Liz Kendall: Does my hon. Friend agree that providing effective information is crucial to driving change in the NHS? The problem is that, as part of their wasted year, the Government finished consulting on their information strategy back in December and still have not published their response.

Grahame M. Morris: It is an enormous task, and I hope that it is successful. As I pointed out, there are considerable risks involved in safeguarding the public interest and ensuring that the data are collected properly.

Owen Smith: Does my hon. Friend agree that another area in which the Bill might cause information to be lost is the “National Confidential Enquiry into Patient Outcome...
and Death” report? That report has previously been conducted by a body that is to be abolished. We now know that the NHS commissioning board might take over the report, but we are not certain.

Grahame M. Morris: Again, that is indicative of a direction of travel that runs counter to clause 265. If we want our interventions to be effective, we need a solid and reliable pool of evidence on which to base our decisions. I regret the Government’s cutting back on that.

The public health observatories are also involved in the important area of collecting information relevant to planning health policy. The rhetoric of openness and transparency, which is often referred to by Members on the Government Front Bench, can be undermined by the axing of moneys—relatively small sums—to resources that are used to survey, collect and collate such information.

I am talking about assembling a proper and accurate evidence base on which to base not just individual choices about treatments or referral patterns, but clinical commissioning decisions and clinical interventions.

Mr Barron: My hon. Friend is right. The issue about public health observatories is that they can monitor the health needs of not just regions and towns but different electoral wards. With the development of the new public health structure, is it not important that organisations such as that are able to give some direction to health and well-being boards and commissioners, to ensure that they understand the health needs and that those needs are met?

Grahame M. Morris: I am grateful to my right hon. Friend. He recently hosted a seminar that my hon. Friend for Middlesbrough South and East Cleveland and I attended, at which those issues were discussed at some length. Such organisations provide a valuable resource and it is essential that they are properly funded. The public health observatories have had a 30% cut this year and there will be a further 30% cut next year.

The director of public health in my own PHO, which is attached to Durham university, indicated that nine of his key staff had been served with redundancy notices. If the Government’s actions are to match their rhetoric, they should ensure that they adequately fund organisations, such as the HSCIC, that the clause is establishing and that due regard is paid to them.

Another issue is that we no longer collect data on the incidence of congenital abnormalities. That is important if we are targeting interventions to identify whether there is a causative link in birth abnormalities and whether there is an environmental cause or some other cause.

Dr Poulter: On that last issue about interventions on birth abnormalities, that sort of information is collected by hospitals. A lot of research goes into that. Those sorts of things are audited and routinely researched by hospitals and clinicians.

On the wider point of public health, what we need is results. We have had many years of collecting data, yet health inequalities are widening in this country, particularly in inner city areas such as Bradford and Liverpool. I am thinking in particular about their heart disease rates. We should have effective public health that works and helps to deal with those health inequalities. Data collection alone is not good enough.

The Chair: Order. We are going very wide of clause 265. There is not a licence to discuss absolutely anything at all. I am also assuming that the hon. Gentleman wants the Minister to reply to some of the points that he raised.

Grahame M. Morris: Clause 265 is establishing the HSCIC, which is a data resource to which patients will have access. It is a linked point in relation to the other potential sources of data. In response to the point that has just been raised, we did see evidence that was presented at the seminar that showed that substantial progress has been made. Specific examples of interventions for coronary heart disease, some linked to the advent of statins, were demonstrated graphically.

Dr Poulter: Actually, the research into statins and related data has nothing to do with the data collection that the hon. Gentleman is talking about. It is the research and the evidence base created in universities and teaching hospitals.

Grahame M. Morris: It is, in a sense. The issue was raised about ineffective interventions to address health inequalities, but in fact the areas mentioned in the big northern cities have very high incidences of coronary heart disease—much higher than the national average. There is ample evidence of that, demonstrated graphically from large collections of data.

6 pm

Mr Barron: Will my hon. Friend give way?

Grahame M. Morris: I will give way to my right hon. Friend, if you do not mind, Mr Gale.

The Chair: The hon. Gentleman can give way if he wishes.

Mr Barron: My hon. Friend is right. The graph that we saw of heart problems in the north-east shows that the gap is closing rapidly, getting somewhere near the national average. Statins were one reason; another was smoking cessation and other measures introduced in the past decade.

People in the north-east should feel that we are getting there, long journey though it is. We are closing some of the major gaps of health inequalities in the UK. I hope we are not going to lose any information on that. We are putting in the Bill that lowering health inequalities has to be done by statute. It seems that under those circumstances the areas that my hon. Friend has talked about are going to be crucial in measuring the effectiveness of the legislation.

Grahame M. Morris: I am grateful. I reassure the hon. Member for Central Suffolk and North Ipswich that we do support the clause and the Government’s
amendments. We simply seek clarification about some of the risks and the issues that need to be properly balanced. We also seek to establish whether there is a conflict with the direction of travel of some other areas of Government policy on health and the collection of data. If the Minister is able to offer any clarification and reassurance regarding the risks of failure, that will be most instructive.

Paul Burstow: I thank the hon. Member for Easington for the full exposition of chapter 2 of the Bill, which he has managed cunningly to weave in to a speech about a relatively narrow clause about the Secretary of State’s functions with regard to significant failure.

I congratulate him on the way he did so, because he has raised a number of issues, some of which I will attempt to address. I will not address all of them as I would have to stay far too wide. Before we conclude today, some hon. Members might want to ensure that we scrutinise the remaining clauses. I am sure we all have an appetite to ensure that we do.

At present the role of the Secretary of State is in effect to veto anything the Information Centre can do by virtue of its status as a special health authority. The Secretary of State could do that with the stroke of a pen, because the functions are not currently protected by statute. That is one reason, yet again, that the Government through the Bill are placing into statute the necessary protections for the independence of the Information Centre. That is in a way answers many of the concerns that the hon. Gentleman has rehearsed today.

The hon. Gentleman also asked when the Secretary of State will perform the role of the Information Centre in the event of a significant failure. The example might be if the Information Centre had failed or was failing to collect and disseminate critical information relating to hospital mortality figures.

There are also some points to make about checks and balances, with regard to the Secretary of State’s discretion. What we have tried to do with the amendment and with the clause is ensure that the balance is struck in a way so as to maximise the autonomy of the Information Centre, so that it can do its job. We have a golden opportunity, because the NHS is in a unique position to draw on LINks data sets on a scale unprecedented elsewhere in the world—for research and innovation and to improve patient care, diagnosis and treatment. Protection for patients’ confidentiality and privacy is fundamental, and we aim to ensure that no initiative threatens it. That is a key principle. The hon. Gentleman asked if it is some sort of privatisation mechanism to pass off to others or parcel up information so that it becomes the property of private enterprise. The answer to that question is, absolutely not.

Fiona O’Donnell: Will the Minister give way?

Paul Burstow: No, we have had a very lengthy exposition and I want to give a brief response to the points the hon. Gentleman made.

The information centre’s published data will continue to be available free of charge. We are not taking information away; we are opening it up. We expect that in addition to patients and clinicians using the data, other organisations will be able to use them to create innovative tools and analysis. That will be a successful way in which the NHS and the public can feel that there is a value to the data that are being collected, much of which are currently hoarded and not widely available for such purposes. The clause is about reinforcing the ability of the organisation to address many concerns.

Grahame M. Morris: Does the Minister feel that the withdrawal of funding for the general lifestyle survey is a good idea? It runs counter to the principles he has just been espousing.

Paul Burstow: As I was going on to say, we debated it in Committee in March, but discussions are ongoing with the information centre to identify the most appropriate way of collecting the health specific elements of the general lifestyle survey. We agree about the value of many parts of it, so we want to keep them going. We are working with the information centre to that effect. With that reassurance, I hope the Committee will agree that the clause should stand part of the Bill.

Question put and agreed to.

Clause 265, as amended, accordingly ordered to stand part of the Bill.

Clause 285

Requirement for Secretary of State to approve remuneration policy etc.

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

The Chair: With this we will also consider clause 286 stand part.

Emily Thornberry: The clauses are important because they are about the Care Quality Commission. Clause 285 requires the Secretary of State to approve remuneration policy and clause 286—“Conduct of reviews etc. by Care Quality Commission”—allows the CQC to conduct an investigation “without the approval of the Secretary of State where the Commission considers there to be a risk to the health, safety or welfare of persons receiving health or social care.”

The debate is timely. There is great concern about the effectiveness of the clause, not least due to the evidence Dame Jo Williams gave to the Select Committee on Health on 28 June. She stated that her view and the view of the CQC was that it was £15 million underfunded. It has 350 staff vacancies, 120 of which are for inspectors. As we all know, the CQC was supposed to be responsible for registering GPs, but due to the backlog of work and its inability to handle everything the Government are asking it to do, it will not be able to deal with GP registration when it was supposed to. That task has been put off until 2014. She also said in evidence that “at the very least” she would like to double the number of inspections.

The changes made to the inspection regime urgently need to be reviewed. For the clause to work properly and for the CQC and the very sensible people who run it—I do not necessarily agree with some of the comments made earlier—to be able to take decisions about what they feel they should be doing, as opposed to what they
can do, very many more inspections will be undertaken and there will be many more investigations. As we saw with Winterbourne View, the CQC is having great problems coping. Given the background, the shortage of money, shortage of inspectors and manifest failure in relation to Winterbourne View, we now expect the CQC to register the Southern Cross landlords who have unilaterally taken control of the more than 750 homes that Southern Cross was running. The landlords have taken back control and will need to be able to provide alternative care providers that will need to be registered with the CQC.

The right hon. Gentleman has told us of the increased number of inspections of Southern Cross by the CQC, but can he tell us how many more inspections have been done and how many more are expected between now and the middle of October when, as I understand it, Southern Cross will cease to exist? At that point, I respectfully and somewhat optimistically suggest, it is anticipated that all the landlords will have found sufficient care providers that can provide care of a sufficiently good standard, and also that care will be provided by organisations that can be financially stress-tested, because the last thing that we want is for a Southern Cross home care provider to cease to exist. We do not want it to go through all the uncertainties about what is to happen, and then for a new care provider to be found that in turn goes out of business six months later.

The CQC and local authorities will have a very important role. They have already said that they want to have more investigations, but we know what the reality is, which is why it is important to debate this now and get more information from the Minister about how we can expect the CQC to be able to perform its functions properly.

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

Emily Thornberry: Given that we have a limited amount of time, I hope that the hon. Gentleman will not spend his time talking about the previous Government and changes that have been made. Let us talk about now and how we can best deal with the situation now.

Fiona O’Donnell rose—

Emily Thornberry: Of course I will give way.

Fiona O’Donnell: I absolutely understand why my hon. Friend did not hear me. She was clearly very passionate and sincere in what she was saying. Can she give me the benefit of her wisdom on whether there is anything in the clause that will address the growing problem of adequately monitoring the quality of community-based services where there is no peer support or supervision? The only person is the service user themselves.

Emily Thornberry: An additional difficulty is that the CQC no longer has a role in inspecting local authorities, which of course has conveniently coincided with the massive cuts that the Government have imposed on local authorities’ ability to deliver social care. So, local authorities are no longer being inspected by the CQC. For example, if my mother wanted to retire and she was wondering whether she wanted to go to Surrey or Sussex, there would be no report available to her so that she would know what the standard of care was in those two neighbouring counties. There is no central assessment of such data, which there used to be. The Government have made a specific decision about that, which means that even if the CQC had the resources and wanted to be able to assess local authorities and their delivery of social care in their area, it would not be able to, even if it wanted to within this section. That is my understanding, but if I am wrong, I will be interested to hear what the Minister says.

The CQC is clearly under strain; we do not want it to fail. It absolutely must not fail. The CQC is now about what is safe. We must make sure that our social care system is safe, that it is properly resourced and that it can do its job properly. Frankly, I am very concerned about the way in which the Department of Health is pushing the CQC out into the cold and allowing it to get on with things and saying, “It’s nothing to do with us; it’s entirely its responsibility.” I respectfully suggest it is very far from being just the CQC’s responsibility; it is the Department of Health’s responsibility and it should step up to its responsibilities.

The Chair: Order. Before I call the Minister, this is not the place in which to have an in-depth debate about Southern Cross. However, in view of the topicality, and importance of the matter to many hon. Members on both sides, if the Minister wishes to make a brief comment about it, I shall allow him to do so.

6.15 pm

Paul Burstow: Let us start with the point of agreement. We absolutely share an interest in ensuring that those who are cared for and supported in the community, be they in residential care or in their own homes, receive good services that meet the necessary standards of quality and safety. Any suggestion that there might be a difference of opinion about that would be unhelpful to what should be regarded as a common enterprise in trying to ensure that we do the very best by those who have sent us here.

The hon. Lady raises several questions about the role of the CQC. She suggests that we must learn lessons about how it is working and she urges us not to dwell on the past. That is curious, because when we try to learn lessons, we need to look at the past to draw conclusions. The Health and Social Care Act 2008 established the CQC, bringing together previous regulators. The measure was introduced by the previous Government and it had the then Opposition’s broad support. The proposition that the regulator should move from setting standards about star ratings to licensing on a set of essential standards of quality and safety was, again, broadly accepted across the House.

The scheme came into effect last October and the CQC did much work to get to that point; ensuring that it had a satisfactory level of resourcing in order to do its work well took a lot of business planning. It is wrong and unfair to gloss over the necessary work that got the CQC into a position to do its work in relation to
registering all the appropriate organisations for October 2010. A very good job was done in circumstances that were constrained by the resources that had been made available up until that time—and that was the position that this Government inherited. We should not gloss over that point and I want to ensure that it is on the record. [Interruption.] I want to make further progress and then I will take some interventions.

This Government’s obligation is that the Department should continue to have responsibility, as the sponsoring Department of the CQC, to agree with it the necessary financial resources for it to discharge its statutory duties. A business plan is in process and we are clear what resources the CQC needs. We continue to have discussions with it so that we are satisfied that it can discharge its functions.

Reference has been made to registration of dentistry and general practitioners. We have decided to pause—to use that phrase—the work on GP registration, which is being put back to April 2013. We are doing that because we believe it will allow the CQC to refine its systems in the light of experience, which is something that, effectively, the hon. Lady encouraged us to do in her remarks. Such experience will be drawn from the CQC’s experience of registering dentists and other NHS and health care providers.

The hon. Lady discussed the desirability—or from her point of view, the undesirability—of sector-led improvement. We have agreed with local government that it wants to work—and is working—with the Department to take forward sector-led improvement in social care. Significant and good progress has been made, and the Department is providing up to £550,000 to enable sector-led improvement work to continue.

The hon. Lady made no reference to a measure that is absolutely key to people’s ability to make the very comparisons that she said are not possible. Comparisons are possible and will be even more so in future, because not only will we have an outcomes framework for the NHS, we will also have one for social care. For the first time, people will be able to make comparisons across a range of outcome domains in the quality of social care. Such comparisons will be useful to those responsible on the ground for challenging poor practice.

Emily Thornberry: Will the Minister give way, because I want him to explain what he just said?

Paul Burstow: I am developing my theme; if I stop, I may lose the thread. I understand that the hon. Lady may wish me to do so, but I want to stick with it.

The hon. Lady also expressed concern that the CQC might no longer have a role in commissioning. It will still, rightly, have step-in powers. On her specific concern that someone would not know what quality of care was provided by a domiciliary care provider or in a residential home, care providers will still be registered, inspected and licensed by the CQC. That deals with that concern.

Fiona O’Donnell: Given the seismic change in domiciliary community-based services and residential care, people are now staying at home who need far more support. The qualifications of the work force have fallen behind the needs of service users. The same is true in nursing and residential homes. We are left with a population— [Interruption.] Sorry, I will carry on with my intervention. I was not sure whether the Minister was still listening.

Paul Burstow: I was listening.

Fiona O’Donnell: I will continue. The needs of patients and residents in residential and nursing homes have also changed. One solution with no cost for the CQC would be to reconsider staff qualification levels.

Paul Burstow: In conducting its responsibilities, the regulator has a responsibility to ensure the right staff mix to deliver the essential standards. That is part of its inspection responsibilities. If there is concern about that, that concern should have been addressed in the design and implementation of the CQC. We need to consider those concerns now as part of the ongoing reviews in relation to Winterbourne View.

I find it frustrating that I spent nearly 14 years on the Opposition Benches arguing for some of the things that the present Opposition are now arguing for but which they never enacted. We were assured for years that changes would be made to the professional regulation of domiciliary care workers, but that never took place. I find it quite extraordinary that those issues are now being rehearsed. I will give way to my hon. Friend the Member for Central Suffolk and North Ipswich before discussing Winterbourne View.

Dr Poulter: Does the Minister agree that there is a role for doctors, nurses and midwives to take more responsibility as professionals—the NMC has acknowledged that more must be done in the professions—for addressing some of the training issues? It is not just down to Government regulation; professionals have a duty to deal with it as well.

Paul Burstow: That is absolutely true, and it allows me to move on to Winterbourne View. Unfairly, the spotlight has tended to turn straight to the CQC when it comes to responsibility for what happened at Winterbourne View. The first responsibilities must sit with the staff, the employer and the company that runs the services. Their duties of care and the duties of medical staff in those organisations are also relevant. We should not gloss over those things either. They must be considered carefully and critically as we review all the different bits of work now being done regarding Winterbourne View.

Dr Poulter: Does the Minister agree that there is a role for doctors, nurses and midwives to take more responsibility as professionals—the NMC has acknowledged that more must be done in the professions—

Paul Burstow: Let me develop my point a bit further. The hon. Lady went on to suggest that Winterbourne View was further evidence for her contention that staff shortages were the reason why the CQC did not spot those things and, as a consequence, why what happened at Winterbourne View happened. That is a massive jump to conclusions that raises questions about her suggestion that a review is needed. Surely we need a review before we jump to conclusions. We should have the evidence from those reviews before we start reaching conclusions.

Grahame M. Morris: Will the Minister give way?

Paul Burstow: No. I want to answer some of the questions that I have been asked about Southern Cross. If I do not, I will be told that I did not answer them. You have said, Mr Gale, that I have a little leeway to answer those questions briefly.
The CQC staff who are specifically responsible for managing ongoing engagement with companies that provide services have regular and more detailed and extensive engagement with Southern Cross than they would with a less vulnerable provider. There are meetings almost daily and the CQC is in phone contact with the organisation, making sure that it stays in touch in a way that is sensible and appropriate to reassure everyone that it is doing its job as a regulator well.

The hon. Member for Islington South and Finsbury suggests that the landlords have unilaterally taken back their assets. The reality, as I outlined in the House a couple of days ago and on 16 June, is that the restructuring committee, of which Southern Cross is a part, has been deliberating on a number of options to allow a smooth transition from the current company to new operators running the care homes. As a Government we have been working with the CQC and the other parties with a statutory responsibility, such as local authorities, to make sure that all the pieces are in place for that smooth transition. I attempted to set that out in my statement to the House on Tuesday. It is not necessary to conclude that the CQC is not capable of coping with that.

The hon. Lady spoke about staffing. Last October, during the staffing freeze that the Government imposed as part of our initial steps, we exempted CQC to enable it to recruit 75 additional staff. Since that time the freeze has been lifted completely, so that CQC is able to recruit the staff it believes it needs to fill its vacancies. In other words, it has the resources and the means it needs. It is not a question of the Government restricting it or preventing it from doing that; it is perfectly able to do just that.

The clause introduces a requirement on the CQC to obtain the approval of the Secretary of State on its pay and remuneration policies before making any determination for the staff it employs. Our debate has probably gone somewhat wider than that, but they are important matters that go to the heart of the way in which the CQC discharges its responsibilities. It is wrong of the hon. Lady to gloss over the fact that much of the work done to establish the CQC—the business planning and the resource decisions—was undertaken by the previous Government and the present Government are dealing with the consequences.

Emmy Thornberry: I regret that the Minister would not let me intervene on a number of points that he raised. What he has just said is simply inaccurate and, frankly, it does not add to debate to take interventions, but not from the shadow Minister. For example, the Minister said that CQC had been set up and that the registration of the organisations last autumn had been done well. I am sure that he listened to the Radio 4 programme that made it perfectly clear that homes that had failed were simply reregistering and therefore being passed. I am sure that he knows that. I am sure he also knows that at least a dozen high-quality homes were publicised by CQC as having failed. I know that because one of those homes is my father’s. To say that CQC had been established and had managed to register all these homes in that time and done it well is simply not accurate.

Some time ago the Minister explained how one could compare one county with another. I simply did not understand one sentence he came out with. He talked about the outcomes framework for social care. de dum de dum de dum—I did not get the rest of it. I want him to explain what that is, so that someone in the street can understand how they can compare one local authority’s standards of social care with another’s. If he does us the courtesy of speaking in a language we understand, so that we can speak to our constituents about this important matter, I shall be hugely grateful.

I will not go through all the points that I intended to make, but I have to say that we should not jump to any conclusions about Winterbourne View. Anyone visiting Winterbourne View could see that all that was available were bedrooms and a television room. There were no functions; there was nothing for the residents to do. The sexes were mixed. Frankly, anyone visiting Winterbourne View would realise that the fundamental role of those who looked after the residents was to keep them inside the home and to keep them quiet—essentially, theirs was a jailer’s role. I will not go into the matter further, but it is a subject of huge debate. The CQC visited the property on a number of occasions and ought to have understood that something was fundamentally wrong with the organisation, without even seeing the abuse going on. The CQC should have known simply from seeing the structural problems at Winterbourne View. No alarm bells went off, which shows that there are fundamental problems with the CQC.

6.30 pm

The Chair: Order. I allowed a degree of leeway on Southern Cross because I thought it important to do so. However, while I do not suggest for one moment that Winterbourne View is not important, it probably warrants another debate in another place rather than here.

Question put and agreed to.

Clause 285 accordingly ordered to stand part of the Bill.

Clause 286

CONDUCT OF REVIEWS ETC. BY CARE QUALITY COMMISSION

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

The Committee divided: Ayes 12, Noes 10.

Division No. 33]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burston, Paul
Byles, Dan
de Bois, Nick
James, Margot

NOES

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

Question accordingly agreed to.

Clause 286 ordered to stand part of the Bill.
Clause 295

Regulations, Orders and Directions

Amendments made: 224, in clause 295, page 245, line 45, leave out paragraph (j).

Amendment 225, in clause 295, page 246, line 16, after ‘and’, insert ‘subject to section 63(3)’.—(Paul Burstow.)

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

Emily Thornberry: Clause 295(5)(a) provides for regulations to be made to extend Monitor’s functions to adult social care services. My concern is to ensure that that is done in a timely fashion, because at the moment, as the Minister knows, there is a clearly a great hole in the regulation of the private sector, particularly in the running of social care homes. Southern Cross is the most relevant example, and we have to learn lessons from that and move on. Although I heard the Minister say that proposals for appropriate regulation of the private sector in the provision of social care will be introduced in the White Paper in the spring, I am worried that, in the meantime, a great deal will happen in relation to Southern Cross. How will the Government proceed on that and what will the regulation be?

It is important to put on the record that Southern Cross is not the sole concern. As the Minister knows, a number of care homes, some relatively large chains, are in difficulty. He does not need me to help him by naming them; we all know which ones they are. Several hundred homes will experience difficulties over the next few months, but there seems to be no safety net or regulation, and no power to intervene other than the peripheral powers of CQC and the powers of local authorities in relation to commissioning. It is important to have some power to intervene, particularly when one provider collapses and a new one comes forward. When we create a new provider, we must ensure that it is undeniably robust.

I have spoken to clause 295 because I want to put our concern on the record. If the suggested new powers of Monitor, or something of the equipment, only come out in the White Paper in the spring, how long will it take to get them into legislation? We need to be able to move fast, particularly in light of the huge cuts that are being made in a timely fashion, because at the moment, that is done in a prescriptive, expensive and bureaucratic regulation of the care home sector, which has greatly exacerbated the crisis in care and has led to many care home closures.”—[Official Report, 7 January 2004; Vol. 416, c. 324.]

Mr Burns: Will the hon. Lady give way on that point?

The Chair: She is just about to sit down.

Mr Burns: Fortunately, I caught the hon. Lady just before she could leave that hanging. She failed to put those comments into the context of what was going on at the time. That context was the regulator for that sector sending inspectors round with tape measures and creating problems by insisting on bathrooms being installed and other measures that were not relevant to the people living in the homes, causing a number of the homes to become bankrupt. In addition, there was no consistency: inspectors in one county would say one thing, but inspectors in another county would say another—

The Chair: Order. We have managed to get this far with reasonably good humour on both sides of the Committee and we are going to stick to that for the rest of our deliberations. I said to the hon. Member for Islington South and Finsbury that I was willing to allow a certain amount of leeway on Southern Cross because it was topical and important, but she has stretched the point about as far as she reasonably can—I put it no higher than that. If I were doing my job properly, I would be inviting the Minister, if he so wishes, to write that paragraph out. I have spoken to clause 295 because I want to put our concern on the record. If the suggested new powers of Monitor, or something of the equipment, only come out in the White Paper in the spring, how long will it take to get them into legislation? We need to be able to move fast, particularly in light of the huge cuts that are being made and the underfunding of social care. I am sure that the hon. Gentleman saw a report from a group that is recognised as an expert in this field that showed that there has been the equivalent of a 3% cut in the money paid to care homes this year.

Paul Burstow: It is Laing and Buisson.

Emily Thornberry: Perhaps Hansard would be kind enough to take that down from the Minister because I have lost my voice. I shall continue. Given how difficult the situation is, the evidence before our eyes shows that the viability of many care homes is being undermined again and again. We will see many more go to the wall and there needs to be some sort of regulation. I am sure that the Minister will ask why we did not introduce regulation when we were in government and we will take that criticism on the chin. However, at the time, we did not have before us the lesson of Southern Cross. Now that that has happened, we need to ensure that we move on and make a robust, immediate response. We also need to ensure that such a situation does not arise again.

I am sure that the Minister will take the opportunity when responding to dissociate himself from the remarks of his ministerial colleague, the right hon. Member for Chelmsford, who proposed an Opposition day motion in 2004 stating:

“That this House expresses its profound concern at the continuing crisis in care for elderly people; deplores the Government’s over-prescriptive, expensive and bureaucratic regulation of the care home sector, which has greatly exacerbated the crisis in care and has led to many care home closures.”—[Official Report, 7 January 2004; Vol. 416, c. 324.]

Mr Burns: The hon. Lady was developing some good points until she descended into the last bit, asking me to comment on my right hon. Friend’s remarks in 2004. However, her underlying point is fair, such as why in July of last year we identified in the White Paper the fact that we should consider extending Monitor’s role to adult social care. It is set out in the Bill in such a way that there is the power to introduce regulations. On several occasions, the hon. Lady has asked why it cannot be done now. We do not have the power to make such regulations until the Bill is enacted. One of the difficulties that the Government have is that, in the current legal framework, the statutory powers to intervene sit primarily with local authorities under existing legislation. That is the cause of concern.

Emily Thornberry: My confusion is that, on the one hand, the Prime Minister, the Secretary of State and the hon. Gentleman are talking about extending the power of Monitor and attaching that power to the Bill. On the
other hand, the hon. Gentleman is also on the record as saying that the new powers to regulate social care will be discussed in the White Paper that we will not see until the spring. What is the time lag? Why are we not getting on with it?

Paul Burstow: The hon. Lady is glossing over the fact that the Bill has to be considered in another place. It will then have to return to this place. It will take a little more time, therefore, until it is enacted. As a consequence, the regulation-making powers that we are discussing mean that we cannot make those regulations. However, we can and are doing the necessary work to ensure that the right set of regulations is in place when we have the powers. The danger—it is a danger—is that we wind up putting in place disproportionate, ineffective regulations that would arrive too late, even were we to have started the Bill some months ago, to deal with the immediate issues of Southern Cross. I have explained our approach to the issue. Yes, over the coming months we will be considering such issues and reaching conclusions that will inform the regulations that will be in the White Paper next spring.

We have had an exchange of views on the role of inspection. It is entirely right to say that inspection has to be more than just measuring the size of rooms. It must be more about other matters such as the quality of life and the experience of individuals. Opposition Members have made such an argument, but it is a criticism of much of the regulatory approach that the previous Government followed for many years.

Emily Thornberry: The hon. Gentleman would not want his aunt or grandmother to be in a home where she has to share a bathroom with others. Does he agree that the changes that were made so that vulnerable people could have some dignity were an achievement?

Paul Burstow: The hon. Lady misrepresents what I have said. It was rather the same with regard to Winterbourne View, where she does not have the full ownership of outrage and shock at what happened there. Those feelings and a desire to see action taken are felt and shared on both sides of the Committee. They are similar when it comes to issues of the quality of care and the experience of people in substandard care. I really find it troubling that the hon. Lady tries to imply otherwise.

Emily Thornberry: If the hon. Gentleman considers that I have implied such things, it may be because we are all very tired. I certainly did not mean to do so. I believe that Opposition Members have a better way to deal with the issue, but I am certainly not questioning the hon. Gentleman’s commitment to ensuring that we improve the situation. I just believe that he is taking the wrong approach.

6.45 pm

Paul Burstow: On that happy note of accord, I urge that the clause stand part of the Bill.

Question put and agreed to.
Clause 295, as amended, accordingly ordered to stand part of the Bill.
not just for us in the House to scrutinise the Bill; we must allow professional bodies, patient groups and others to have their say. Due to the rush with which the Bill has been pushed through, they have not had the chance to do so.

Mr Burns indicated dissent.

Liz Kendall: The Minister shakes his head, but, in the spirit of constructive help, I must tell him that he would have done better to give more time to the Bill, because it will jump back and bite him.

Owen Smith: Does my hon. Friend agree that the Royal College of Physicians submitting evidence today, a fortnight after its president said in evidence to the Committee that he had not had time to read the clauses, is the most telling example of what we have said throughout our proceedings? For us and for people outside who care about the NHS, there has not been enough time to scrutinise this crucial Bill.

The Chair: Order. I gently remind the Opposition Front-Bench team that the clause is about the commencement of the Bill. The hon. Member for Leicester West is being very creative, as she is entitled to be, but she should not overstep the mark.

Liz Kendall: I would never overstep the mark, Mr Gale. I want to explain why I do not think that the Bill should commence, and one reason is that external organisations have not had time to examine it properly.

Mr Barron: As my hon. Friend will see, the first line of subsection (1) states:

“The following provisions come into force on the day on which this Act is passed”.

Would she like to speculate on when that is likely to be, given that we are sitting here for a second Committee stage? Is there any possibility that it will happen next year? Could we be back here again?

Liz Kendall: I am sure that Members in another place will look at the Bill, and at the Government new clauses and amendments that we have been unable to scrutinise. They will see that external bodies are submitting evidence at half-past 4 on the final day of the Committee, and they will conclude that they need to take a long time to scrutinise it properly.

Grahame M. Morris: It seems that day by day and hour by hour, new information that is relevant to the Committee is leaked, and we get it second hand. Information has just been made available, for example, about the clustering of the strategic health authorities into four clusters from 10 clusters. We did not even have the opportunity to discuss clause 28 on the abolition of the strategic health authorities, yet this information is now in the public domain, even though it was withheld from the Committee. It is outrageous.

Paul Burstow: On a point of order, Mr Gale. Will you advise the Committee about the effect of the Committee not approving the commencement clause, in the event that the Government lose the vote? Will it not effectively mean that the Bill will be implemented straight away on enactment?

The Chair: It is not up to the Chair to determine the policy of the Opposition or that of the Government. I believe that the Minister may be correct, but to date, I have had no indication that the Opposition intend to oppose the clause.

Liz Kendall: My hon. Friend the Member for Easington raised the issue of the clustering of SHAs, and he made a point that I will come on to next, which is the reason why we do not want the Bill to pass.

Let us be honest about what has happened here. There has been a massive, top-down reorganisation, causing chaos and confusion in the NHS. The Government, including the Liberal Democrats, have forced a restructuring on to people, which they promised they would not do. If Members have spoken to anyone in their primary care trusts or strategic health authorities, or people in our hospitals who are trying to get changes through, or anyone in the service, they will know that the Government’s plans have caused a huge problem.

What will the result be for patients, who, after all, are what Opposition Members believe in? Last week, we heard that, despite the Prime Minister’s promise to keep control of waiting times, there are four times as many people waiting more than six weeks for their diagnostic tests than at this time last year. There are 10 times more people waiting more than three months, and only yesterday, we heard that 18-week waits are up by a third compared with May last year. Waiting times are also higher than the year-to-year figures from April to April, which were up 24%.

The point, as Nigel Edwards rightly states in today’s The Guardian—[Interruption.] Government Members involved Nigel Edwards in their Future Forum listening programme, so perhaps they would like to listen again. He said that “there has been an obsession with major structural and upheaval change in the NHS in spite of the well-known fact that restructuring loses at least two years of progress.”

Nick de Bois: I have thoroughly enjoyed listening to the hon. Lady throughout the Committee’s deliberations, but I remind her that she is using the Future Forum rather selectively. She should remember that there was overwhelming support. Professor Field himself said, “Let’s just get on with it.” May that be the final word.

Liz Kendall: It will not be the final word because Opposition Members do not want the Bill to proceed, and let me make it clear why. The Secretary of State and the Prime Minister like to say that the choice is between change and no change. They are wrong. The choice is between the right change and the wrong change, and the Bill proposes the wrong change. If Government Members have not picked up on that yet, let me explain why.

We know that the NHS needs to change to deliver better care for people with long-term chronic conditions and for an ageing population. The NHS also needs to centralise some services in specialist centres so that patients benefit from technological advances and from
the enhanced skills of clinicians. The problem with the Government’s approach is that it will help us to achieve neither of those goals; in fact it is likely to make those goals harder to achieve.

The one case of strategic planning that has helped to improve stroke services in London was led by the strategic health authority. I think that the strategic health authorities became too large and should have been reduced, but getting rid of that strategic planning means that we will not be able to repeat the changes that have been achieved in stroke and trauma care.

**Dr Poulter:** The hon. Lady will accept, and we would agree, that one of the key problems in the NHS, as we heard from the witnesses, is that there is too much silo working. The King’s Fund has clearly elaborated in its recent report on silo working among GPs, saying that it does not tackle health care inequalities or the issues involved in dealing with an ageing population. Clearly, the current system does not work very well. The reforms are about tackling issues such as medical comorbidities by putting commissioning in one place, mostly in primary care. That will help to address the problem of an ageing population because there will be co-ordinated thinking and joined-up care.

**Liz Kendall:** The hon. Gentleman is wrong if he thinks that commissioning is in one place. Let me explain to him his own Government’s Bill. There are clinical commissioning groups, clinical senates, clinical networks, health and well-being boards, a National Quality Board and an NHS commissioning bard. NICE has a role, too. That is chaos and confusion. If the hon. Gentleman does not believe me, perhaps he should listen to the evidence submitted today by the Royal College of Physicians. It said:

“The potential complexity introduced by the new system of bodies with advisory roles...delivery functions...oversight responsibilities...and regulatory and performance management responsibilities...must be minimised...there must be clarity on how reconfiguration decisions will be made in practice. The respective roles of clinical commissioning groups, clinical senates, scrutiny committees, Health and Wellbeing Boards, Monitor and the NHS Commissioning Board must be clarified.”

If the body representing hospital doctors, which the hon. Gentleman is himself, says that it is unclear who is responsible and how the changes will be made, the honourable Gentleman should not support the Bill.

**Grahame M. Morris:** On that theme, will my hon. Friend comment on the analysis of Professor Sir Roger Boyle, the heart tsar? He is an eminent doctor and is responsible for driving incredible improvements in outcomes. What is his view on the reforms? Why is he taking early retirement?

**Liz Kendall:** Professor Boyle thinks that the reforms are introducing waste, chaos and confusion. They take money away from front-line patient care. The extra bodies make it unclear who is responsible for leading changes.

Government Members shake their heads and look blank, but they will see in the months and years to come that patient care will go backwards under the Government’s plans. Whatever they claim, the heart of their Bill remains the same. There are 12 clauses on competition law, which is being introduced in the NHS for the first time, but there are no amendments, no changes to those clauses and the Minister has not explained why the Government are bothering to introduce them.
New Clause 3

SECRETARY OF STATE’S DUTY AS TO RESEARCH

‘After section 1C of the National Health Service Act 2006, insert—

“(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) research on matters relevant to the health service, and

(b) the use in the health service of evidence obtained from research.”.

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

(6) Nothing in section 56 requires Monitor to do anything in relation to the supply to persons who provide health care services of goods that are to be provided as part of those services.”

New Clause 5

GENERAL DUTIES: SUPPLEMENTARY

‘(1) This section applies for the purposes of this Part.

(2) “Anti-competitive behaviour” means behaviour which would (or would be likely to) prevent, restrict or distort competition and a reference to preventing anti-competitive behaviour includes a reference to eliminating or reducing the effects (or potential effects) of the behaviour.

(3) “Health care” means all forms of health care provided for individuals, whether relating to physical or mental health, with a reference in this Part to health care services being read accordingly; and for the purposes of this Part it does not matter if a health care service is also an adult social care service (as to which, see section 57).

(4) “The NHS” means the comprehensive health service continued under section 1(1) of the National Health Service Act 2006, except the part of it that is provided in pursuance of the public health functions (within the meaning of that Act) of the Secretary of State or local authorities.

(5) A reference to the provision of health care services for the purposes of the NHS is a reference to their provision for those purposes in accordance with that Act.

(6) Nothing in section 56 requires Monitor to do anything in relation to the supply to persons who provide health care services of goods that are to be provided as part of those services.”

New Clause 6

STANDARD CONDITION AS TO TRANSPARENCY IN SETTING AND APPLICATION OF CERTAIN CRITERIA

‘(1) The standard conditions applicable to any licence under this Chapter must include a condition requiring the licence holder to—

(a) set transparent eligibility and selection criteria, and

(b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the licence holder.

(2) “Eligibility or selection criteria” , in relation to a licence holder, means criteria for determining—

(a) whether a person is eligible, or is to be selected, to receive health care services provided by the licence holder for the purposes of the NHS, and

(b) if the person is selected, the manner in which the services are provided to the person.”.

New Clause 7

CONSULTATION: FURTHER PROVISION

‘(1) For the purpose of securing that the prices payable for the provision of health care services for the purposes of the NHS are such as to result in a fair level of pay for providers of the services, the National Health Service Commissioning Board and Monitor must, in exercising functions under section 117, have regard to—

(a) differences in the costs incurred in providing health care services for the purposes of the NHS to persons of different descriptions, and

(b) differences between providers with respect to the range of health care services that they provide for those purposes.

(2) In exercising functions under section 117(5), the Board and Monitor must act with a view to securing the standardisation throughout England of the specification of health care services in the national tariff under section 115(1)(a).

(3) In exercising functions under section 117(10A), Monitor and the Board must act with a view to securing the standardisation throughout England of the specification of health care services in rules provided for in the national tariff under section 115(3)(b).

(4) In carrying out the duty under subsection (2) or (3), the Board and Monitor must have regard to whether, or to what extent, standardisation is likely to have a significant adverse impact on the provision of health care services for the purposes of the NHS.”.

New Clause 8

FAILURE TO DISCHARGE FUNCTIONS

‘(1) In section 82 of the Health and Social Care Act 2008 (failure by Commission to discharge functions), in subsection (1), at the end insert “, and that the failure is significant.”

(2) After subsection (2) of that section insert—

“(2A) But the Secretary of State may not give a direction under subsection (1) in relation to the performance of functions in a particular case.”

(3) After subsection (3) of that section insert—

“(4) Where the Secretary of State exercises a power under subsection (1) or (3), the Secretary of State must publish the reasons for doing so.”

(4) In section 161 of that Act (orders, regulations and directions: general provisions), in subsection (3), before “any power of the Secretary of State to give directions” insert “subject to section 82(2A)”.

(5) In section 165 of that Act (directions), at the beginning of subsection (2) insert “Subject to subsection (3),”.

(6) After that subsection insert—

“(3) A direction under section 82 must be given by regulations or by an instrument in writing.”.

Brought up.
Question put (single Question on new clauses moved by a Minister of the Crown). That new clauses 1 to 8 be added to the Bill.—(Paul Burstow.)

Question agreed to.

New clauses 1 to 8 accordingly added to the Bill.

Bill, as amended, reported (Standing Order No. 83D(6)).

The Chair: Strictly speaking, the business of the Committee has now ended, but it would be quite improper of me, if of nobody else, not to thank the staff of the House, without whom we could not do the job. [HON. MEMBERS: “Hear, hear!”] No, we do not applaud. I also thank all members of the Committee. It has not been easy, but the proceedings have, by and large, been extremely good humoured. Thank you very much indeed.

7.1 pm

Committee rose.