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GENERAL COMMITTEES

Public Bill Committee

CARE BILL [*LORDS*]

Eleventh Sitting

Tuesday 28 January 2014

(Morning)

CONTENTS

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Saturday 1 February 2014

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

The Committee consisted of the following Members:

Chairs: HUGH BAYLEY, †ANDREW ROSINDELL

† Abrahams, Debbie *(Oldham East and Saddleworth)* (Lab)
† Burstow, Paul *(Sutton and Cheam)* (LD)
† Doyle-Price, Jackie *(Thurrock)* (Con)
† Esterson, Bill *(Sefton Central)* (Lab)
† Griffiths, Andrew *(Burton)* (Con)
† Jones, Andrew *(Harrogate and Knaresborough)* (Con)
† Kendall, Liz *(Leicester West)* (Lab)
† Lamb, Norman *(Minister of State, Department of Health)*
† Lewell-Buck, Mrs Emma *(South Shields)* (Lab)
† Malhotra, Seema *(Feltham and Heston)* (Lab/Co-op)
† Morris, Anne Marie *(Newton Abbot)* (Con)
† Morris, David *(Morecambe and Lunesdale)* (Con)
† Morris, Grahame M. *(Easington)* (Lab)
† Munn, Meg *(Sheffield, Heeley)* (Lab/Co-op)
† Newton, Sarah *(Truro and Falmouth)* (Con)
† Penrose, John *(Weston-super-Mare)* (Con)
† Poulter, Dr Daniel *(Parliamentary Under-Secretary of State for Health)*
† Reed, Mr Jamie *(Copeland)* (Lab)
† Shannon, Jim *(Strangford)* (DUP)
Smith, Nick *(Blaenau Gwent)* (Lab)
† Stephenson, Andrew *(Pendle)* (Con)
† Wheeler, Heather *(South Derbyshire)* (Con)
† Wollaston, Dr Sarah *(Totnes)* (Con)

John-Paul Flaherty, *Committee Clerk*

† attended the Committee

Public Bill Committee

Tuesday 28 January 2014

(Morning)

[Andrew Rosindell *in the Chair*]

Care Bill [*Lords*]

8.55 am

Clause 81

Warning notice

Paul Burstow (Sutton and Cheam) (LD): I beg to move amendment 48, in clause 81, page 72, line 34, at end insert—

'(1A) Regulations must make provision for—

(a) the definition of "significant improvement", and

(b) the assessment of progress towards the improvements so specified.'.

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

Amendment 140, in clause 81, page 73, line 4, at end insert—

'( ) The Commission must publish the criteria that the trust must satisfy in order to be judged as making a significant improvement.'.

Amendment 141, in clause 81, page 73, line 7, at end insert—

'( ) Where a warning notice under this section imposes more than one requirement to improve the quality of health care under subsection (2)(e), the Commission must publish the criteria to be satisfied for each requirement.'.

Amendment 157, in clause 89, page 81, line 44, at end add—

'(10) If a review undertaken by the Commission results in a warning notice being applied under the provisions of section 81, the Commission must publish the criteria the service provider must satisfy in order to be considered as making a significant improvement.'.

Paul Burstow: Good morning, Mr Rosindell. I look forward to another couple of sittings today considering the Bill. Clause 81 is all about warning notices that can be issued by the Care Quality Commission, which trigger a process that ultimately could lead to enforcement action being taken by another body. It is that issue of the division of the CQC's current role as both an inspectorate and an enforcement that I want to explore through the amendments. I want to get some further clarity and an explanation of the rationale for this.

At first glance one might think that the intention behind this change is to enable the CQC to mimic the role of Ofsted. If that is the case it is a misunderstanding of the role of the CQC. Unlike Ofsted, the CQC is a regulator. If one looked at the panoply of powers that are granted to regulators, it would be hard to find many examples where a regulator does not have the necessary competence and powers to enforce as well. In this case, the splitting off of the enforcement responsibilities only applies to health services that are provided directly by the NHS—in other words, foundation trusts and NHS trusts. It does not apply to social care services. It does not apply to those services that are provided by private health care providers even if they are providing those services to the NHS.

I tabled amendment 48 to find out more about the circumstances in which the CQC may impose a warning notice on a provider. That is particularly important given that this is the start of this journey that will now be triggered towards trust special administration. That is the other aspect of this. The 2009 legislation established the idea of trust special administrators and gave them pretty sweeping powers to deal with issues of financial failure. Up until now that has been the locus of that set of provisions in legislation. It has not been to give trust special administrators the additional duty of enforcing issues of quality and safety. It seems a rather odd conflation of two rather different sets of roles within the trust special administration role.

The Bill splits these roles of inspector and enforcer and, as I understand it, that was not one of the recommendations in the Francis report. It is important that the Government take the opportunity to spell out why they have taken this different approach. There is a risk that the split could lead to some confusion. Under clause 81 the Care Quality Commission will be able to place a warning notice on a provider, although the reasons for it are not defined. The explanatory notes state that the warning notice will have to set out the reasons for it but that is not stated in the Bill. The Bill certainly does not set out, as my amendments seek to do, the criteria that will be used to judge whether the CQC's concerns about safety are being addressed to meet the threshold of "significant improvement".

My amendments attempt to provide a mechanism for the Government to give clarity for the CQC and also give clarity when it comes to triggering the trust special administration regime. If improvements are not made, the CQC can go to Monitor for foundation trusts under clause 82, or the Trust Development Authority under clause 83, for trusts that are to be placed in special administration. This process is only for NHS organisations. It does not cover GPs, the private health sector or social care. In those cases the CQC retains its role as an inspectorate and an enforcement body.

I have three points to make about this approach. First, the nature of the quality deficiency and the scale of improvement required are not defined on the face of the Bill. It would be interesting to know whether there is an expectation that regulations would do this. It is not clear that there is a regulation-making power to enable that to happen. This could lead to Monitor or the TDA questioning or even resisting a request and at the very least there being a hiatus or uncertainty whether to act, because they are not necessarily convinced about the quality challenge being sufficiently grave. It could give rise to confusion among NHS organisations, because the rules-based registration requirements in the 2008 Act, which spelled out what is required in safety terms, are being replaced by what is effectively a discretionary system. I can understand why having an element of discretion, especially in matters where there is a need for urgent action, is absolutely necessary. But again, that gives pause for thought whether the TSA route is the way to get urgent action given the necessary time periods that are built into that process.

Secondly, trust special administration was not designed to address quality failures. There is no evidence to justify the view that it would be an effective tool in this

case. The TSA process, although relatively quick in addressing financial failure—for which I think it is appropriate and we will come back to that later—is likely to be too slow to respond to an urgent safety issue. It is also quite disruptive, which in the case of a safety concern should be avoided in such an organisation.

Thirdly, it is not clear why the NHS requires a different safety regime to other regulated services. Will the Minister spell out why there is a difference?

Will the Minister explain why it is necessary to split the roles of inspection and enforcement, but only for the NHS direct provision; set out what steps he is taking to add definition to the warning notice regime, beyond what it says in the explanatory notes; and give serious thought to my amendment? I am sure that there will be technical deficiencies in its drafting, which will make it impossible to be accepted on its own, but I hope that Ministers will give some serious thought to whether leaving open the question of significant improvement—and what standards and criteria should be used to judge that—leaves the whole system open to doubt and confusion. This is an area where we should not be introducing doubt and confusion. I hope the Minister will clarify these matters.

Mr Jamie Reed (Copeland) (Lab): We are nearly there. On the way in this morning, I saw someone with one of those signs proclaiming, "The end is nigh". I knew exactly how he felt.

First, may I express a few civilities? May I say how pleased I am to see the hon. Member for Totnes here with her clear injury? I hope she gets well soon. On my six-hour journey yesterday, I was genuinely saddened to learn of the decision of my hon. Friend the Member for Sheffield, Heeley to leave the House at the next election. She has been a tremendous servant of this place and of her constituents and I will always be grateful to her for the guidance, support and help she has given me since I was elected in 2005. How much effect that has had will be a matter for others to judge, but I am genuinely grateful to her and she will be sadly missed.

Clause 81 seeks to make amendments to the powers of the Care Quality Commission in issuing warning notices to NHS trusts and foundation trusts. I thank the right hon. Member for Sutton and Cheam for his remarks and I shall touch on much of what he said in my contribution. I genuinely sympathise with the issues that the right hon. Member for Sutton and Cheam raises in amendment 48. He is, of course, right about Ofsted. We have used the comparison too frequently with regard to Ofsted and the CQC. It has never been accurate or an effective comparison in my view and I wish that, collectively, we could stop using it, not least because my wife is a teacher and currently going through the Ofsted process. While the fundamental principle behind clause 81 will not draw any criticism from the Opposition, as drafted it would significantly benefit from including more detail.

I want to make three main points about the amendments. First, I want to address this idea of "significant improvement". I worry that this phrase is, by itself, potentially intellectually empty. I hope that the Minister will expand on what the Government mean by it and how it will apply in practice. Do the Government intend to produce guidance on this issue, or is it a judgment to be made by the Care Quality Commission on a case by case basis? Surely the point of the Committee process and of this Bill is for us to seek to remove ambiguity from the regime.

Secondly, I will look at the proposed duty on the CQC to monitor progress made towards the improvements necessary, which is contained in amendment 48. Thirdly, I want to discuss the practical relationship between the Care Quality Commission and individual trusts, in particular the information the CQC provides to them. I urge all hon. Members to note again the emphasis placed on clear communication by Professors Keogh and Berwick, Robert Francis and Professor Hart.

The notion of "significant improvement" appears in the clause a number of times as the marker of what is expected of the trust in question in relation to the warning notice, and as the standard by which the Care Quality Commission must make a judgment on whether the warning notice has been satisfied. Under subsection (4)(a) and (4)(b), the Care Quality Commission must make a judgment about whether the requirement to which the notice relates has been satisfied—in simple terms, has the trust made significant improvement?

Statistically, this idea is meaningless. As an example, say an imaginary indicator moves from a score of 2% to 3%. That is an improvement of 50% on the original performance, which in anyone's eyes is significant, but in reality is no real improvement at all—certainly not in the qualitative sense. Amendment 48 would go some way to addressing this, by ensuring that there is a statutory basis for the definition of "significant improvement" in regard to this clause. This is absolutely necessary, in my view, to give the CQC clarity in its work, and to ensure that the trusts in question have the information that they need to make the improvements which are required of them.

After all, everything in this part of the Bill should be geared to allow, encourage and facilitate improvements in care, which would clearly be welcomed by hon. Members on both sides. However the clause at present simply does not extend to allowing this to take place with sufficient clarity. The legal definition of "significant improvement" is badly needed for three reasons. First, it would give the Care Quality Commission a framework on which to build its judgments about what needs to be improved in a particular trust. Secondly, it would defend the Care Quality Commission and the trust involved against differing interpretations of what constitutes significant improvement. It would give clarity to the procedure from the beginning, rather than fostering division created by discrepancies in the judgments of the constituent parties involved in any improvement process.

Thirdly, a clearer definition would give the trust a clearer aspiration to reach, which makes it more realistic to attain. It would cultivate a more constructive dialogue between the service regulator and the service provider and this, in its own way, would save resources as well as expediting the process of making improvements. Crucially, this would be better for patients, by removing ambiguity and ensuring a faster rate of improvement in the quality of their care.

The key to making warning notices as effective as possible is to ensure that the trust is focused on improving the standards of care under their provision. The antithesis of this would be in legislating for a too-loose framework,

[Mr Jamie Reed]

which consumes the resources of the CQC and trusts in arguments about semantics and definitions. This would build avoidable ambiguity and unnecessary delay into the failure regime.

The Minister will have the chance to respond to these points shortly. Without wishing to prejudge his remarks, he may suggest that the current clause would build a framework flexible enough for the CQC to mould to make it appropriate for the case in front of it. However, there is nothing in the right hon. Gentleman's amendment, or those I tabled, that would preclude flexibility.

Secondly, new section 29A(4)(b) is an extremely useful addition to the Bill. Where significant care failings occur, it is right that after imposing requirements on the trust the regulator should be required to monitor the trust's progress in fulfilling those requirements. It is absolutely essential that the regulator keeps a close eye on the trust to ensure that improvements are being made and, more importantly, maintained. Monitoring will also ensure that the trust has support mechanisms in place to best facilitate speedy improvements. Through this a close relationship will be cultivated, which can be invaluable in these circumstances. It allows better communication and encourages a more candid approach, in turn giving the trust far greater ownership in judging its own performance and meeting the targets it has been set.

I have spoken in some detail so far about the reasoning behind a statutory definition of significant improvement in respect of this clause. In doing so, I have spoken in detail about amendment 48. Members of this Committee will no doubt have noticed that our amendments are drawn from the same ideas and principles as those behind amendment 48. Our amendments differ from the one tabled by the right hon. Member for Sutton and Cheam in that it would place additional duties on the Care Quality Commission to provide clarity. Whereas amendment 48 gives a definition on a national level, our amendments seek to provide clarity on an individual, case-by-case basis. This prescription is based on both experience and also—I must be honest—the weight of my postbag of late.

In July last year, Professor Sir Bruce Keogh published his report into hospital mortality rates. Although I have mentioned this in previous sessions, I want to take this opportunity to thank Professor Keogh for his work and for the genuinely superb report he published. It has informed many of the amendments we have tabled throughout this section and the next section of the Bill. My local trust was among those investigated by Sir Bruce, and my experience of local conditions—and, indeed, what my local community has gone through since the report was published—is manifest in the form of amendments 140 and 141.

It is not news to anyone on this Committee that, after the publication of the report, 11 of the 14 trusts investigated by Sir Bruce were put into special measures. One of them was my local trust, the North Cumbria University Hospitals NHS Trust. Despite numerous letters and parliamentary questions, I am none the wiser as to what the term "special measures" means in relation to the specific findings set out in Sir Bruce's report on. It appears to be as ambiguous a term as the current definition of "significant improvement".

Due to widespread fear that an ongoing trust acquisition process—more on which later, no doubt—and the Keogh review would result in major services being stripped out of the local health economy, I hosted a health summit with local clinicians and others on 30 September last year. The defining message from this summit was that there had been no clear communication between the North Cumbria trust and the Department of Health to determine how the term special measures applied to the trust. Even more damagingly, given the connotations of a trust being placed in special measures and the impact of this on the public's confidence in local health services, the trust had not yet received any information on how it could leave special measures. The effect of this was to leave clinicians, commissioners, managers and patients in limbo. None of us would want our car to be MOT-ed on such conditions. This is the basis of our amendment. In order for this trust and others like it to effectively tackle the problems they face, they need to know what they must achieve to be judged as providing good quality care.

Clause 81(3) amends the Health and Social Care Act 2008. Under new section 29A(2), the CQC will be required to do four things. First, the CQC must state that it has come to the opinion that the quality of healthcare provided by the trust must improve. Secondly, the CQC must identify the service requiring the improvement. Thirdly, it must justify its reasoning, before finally placing a requirement on the trust to make a significant improvement. Our amendment would add a fifth duty on the CQC, requiring it to set out the criteria or the level to which the trust must perform in order to satisfy the requirement to make a significant improvement.

In areas of prolonged, systemic difficulty—we can all point to those trusts on a map—where care is potentially based on locum cover, in many instances such a move is essential. This proposal would not only constitute a logical extension of what is already required of the commission, but would also provide stability to the trust in question by giving it clear direction and well defined parameters within which to focus its work.

9.15 am

The amendment would not tie the Care Quality Commission to particular criteria, as there is nothing in it that would prejudice the CQC's applying further warning notices. Having received a response from the Minister to a parliamentary question on the definition of special measures, I understand that there is a broad national definition. That national application of language is welcome and clearly has a place in the context of the clause, which is why the right hon. Member for Sutton and Cheam can count on our support for his amendment, but that national definition means little in a local setting, which is where any improvements will be made and maintained. The extent to which a service must be improved needs to be enumerated clearly, so that the trust can plan and attribute adequate and sufficient resources to ensure that poor services are improved swiftly.

Andrew Griffiths (Burton) (Con): I understand the hon. Gentleman's point about the need for clarity, but my local hospital, Queen's hospital, is also a Keogh hospital—it is in special measures. It is clear reading the report what Sir Bruce wants my hospital to do to meet the standards required. Why does the hon. Gentleman think that is not clear enough?

Mr Reed: I simply turn the question around: is there anything in that report that places a statutory duty on the CQC or the trust to achieve the ambitions set out in Sir Bruce's recommendations? The answer is that it does not. I believe I seek the same end as the hon. Gentleman: clearer, faster, better ways for our hospitals, for which we both campaign, to get out of special measures. The point of that is to improve patient care more rapidly as well.

I was pointing out that the right hon. Member for Sutton and Cheam can count on our support for his amendment. The CQC needs to give greater clarity to trusts under its inspection regime. The clause puts a duty on the CQC to give notice to the trust that it must improve, and we welcome that, but the current wording puts no requirement on the regulator to explain what level of service the trust must reach in order for the warning notice criteria to be satisfied. To do so would surely make the task of improving patient care swifter. In short, we seek a quantitative assurance in regard to warning notices.

Our position does not contradict the essence of the clause or the Government's intention and purpose. In fact, it would do the opposite, by strengthening the principles of warning notices and guiding the CQC to execute its duties in a more efficient manner that will ultimately benefit patients. It cannot be the role of the regulator simply to highlight a problem and then walk away; nor is it the role of the regulator to micro-manage the trust to make improvements. There is an equilibrium to be achieved, and we believe our amendment would go a long way to reach that by imposing a duty on the CQC that would deliver clearer communication between the regulator and the trust.

We all recognise that, whatever the reasons, there is a febrile environment around health policy at the moment. Trusts have to operate and clinicians work in that environment. We must guard against trusts believing that they are being set up to fail; that serves nobody's interests.

My detailed knowledge of regulation and regulatory practice stems from my background in the nuclear industry, which is probably the most regulated industry in the world. Let us bear in mind the significant risks associated with regulatory failures there. The model of regulation used by the Government in that industry is entirely iterative: for obvious reasons, the regulator does not wait for a nuclear operator to fail. It has been through that experience and process and clearly found the shortcomings in such an approach, so it now works on the basis of no surprises. That is clearly an intelligent and effective way to work. It adopts an iterative process and works on a regular basis with the bodies it seeks to regulate.

The application of a warning notice can be effective only if it is executed on two fundamental points. First, as I have noted previously, it is essential that the warning notices are used and applied as a tool to improve care, not simply to place a trust in the stocks in the town square. Secondly, any warning notice should act as a de facto contract between the regulator and the regulated service provider, by which I mean that the imposition of a warning notice should create a partnership geared towards ensuring co-operation that will ultimately improve the outcome of the process for the benefit of patients, clinicians and the local community the trust serves. By giving clarity of purpose to the body that is required to improve services, in whatever respect that may be, the trust will be well equipped to tackle problems efficiently. In its unamended form, the clause only gives the service provider an unclear view of what is needed. Amendments 140 and 141 would require the Care Quality Commission to empower the trust by giving more information, more direction and much greater clarity.

Given that the amendments are a step forward in removing ambiguity, I hope that the right hon. Member for Sutton and Cheam will test the will of the Committee on the lead amendment. If he does, he will do so in the knowledge that he has the support of Opposition Members. As I mentioned, I believe that our amendment goes further than the right hon. Gentleman's, so when the time comes I might test the will of the Committee.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): It is a pleasure to serve under your chairmanship, Mr Rosindell. I echo the comments of the hon. Member for Copeland about the hon. Member for Sheffield, Heeley, for whom I have a lot of time. She has been a diligent servant of her constituents and has contributed at a high level in this place. Her valuable contributions will be missed across the House, and I am sure we would all like to thank her for her service to the House, the country and her constituents.

Before speaking specifically to the amendments, I hope the Committee will find it helpful if I reflect briefly on the background to clauses 81 to 84. We are all painfully aware of the report into the failings at the Mid Staffordshire NHS Foundation Trust, in which Robert Francis set out how regulators, commissioners, professional bodies and the Department of Health all failed to act together in the interests of patients and high-quality, compassionate care. It was a humbling report, and last year was a humbling year for the NHS and all of us who work in the NHS and believe in our health service. That is why we need to act to make sure that, as best we can, we prevent the terrible failings that occurred at Mid Staffordshire from happening again. That is why in the Bill we are providing for a single failure regime, which will ensure as great an emphasis on quality of care as there is on prudent and sustainable financial management, and greater clarity of the roles of the regulators. The Care Quality Commission will focus on assessing and reporting on quality and quality of care, and Monitor and the NHS Trust Development Authority will be responsible for using their enforcement powers to ensure that improvement is made. That will provide a simple, flexible process for identifying and tackling failures of quality, governance and finance at NHS trusts and foundation trusts.

Clause 81 provides a legislative basis for the CQC to identify problems and require improvement within a specified period. It enables the CQC to issue a new type of warning notice to NHS trusts and foundation trusts, if the quality of services they provide requires significant improvement. In future, the CQC will focus on performance assessments and compliance with the new fundamental standards being developed in the wake of the Francis inquiry. The draft fundamental standards and accompanying regulations were published for consultation last week, and in their final form will be set out in regulations and in CQC guidance. The Bill will ensure that the CQC has the flexibility it needs to require

[Dr Daniel Poulter]

necessary action in any circumstance, whether a breach of fundamental standards or any other undesirable practice identified by the new chief inspector of hospitals is detrimental to patient care.

Amendment 48, tabled by my right hon. Friend the Member for Sutton and Cheam, would require regulations to set out the detail of what "significant improvement" entails and how the CQC will assess progress in making that improvement. I hope to reassure him that we can avoid the doubt and confusion in the existing framework with the provisions of these clauses. I agree with him that that is important. That is why clause 81(5) will amend the Health and Social Care Act 2008 to require the CQC to publish guidance to detail their approach to issuing the new warning notices. The CQC's existing guidance on warning notices will be revised in the light of the Bill to include the CQC's interpretation of when significant improvement would be required. In addition, the CQC, Monitor and the NHS Trust Development Authority will publish further joint guidance on how they will work together to address risks to quality and bring together financial performance and quality in the same judgment, where appropriate. This will set out how the CQC will assess progress and work with Monitor and the TDA to ensure action is taken.

Defining the meaning of "significant improvement" in regulations, as amendment 48 would require, is, I hope my right hon. Friend will agree after I have further reassured him, a rigid and inflexible approach that could prevent the CQC from acting where it needs to do so in the interests of patients. It is important that the CQC's judgments have credibility. That is why it should be for the chief inspector of hospitals, Professor Sir Mike Richards, who commands widespread respect in the health service and across this Committee, I am sure, to determine the most appropriate interpretation of significant improvement and to detail this in statutory guidance. We must remember the assessments are clinically led. It is not for Whitehall to tie the hands of clinicians in assessing the quality of care.

My right hon. Friend also asked about NHS bodies other than trusts and foundation trusts and about social care and the independent sector. He will be aware that all providers of regulated health and adult social care services must be registered with the CQC. The CQC already has a range of enforcement powers, including issuing warning notices, prosecuting breaches of standards, and suspending or removing registration of providers. Those powers work well in most of the sector, but they are less effective for large acute trusts, as the Francis inquiry identified, and that is why we need the changes. Importantly, issues of financial sustainability and quality of care are brought together by the clauses. It is no longer appropriate to see those in isolation.

Amendments 140, 141 and 157 deal with the information to be included in the new warning notice, including where a warning notice is issued following a performance assessment. The CQC would be required to publish criteria that an individual trust was required to satisfy in each case. The content of the new notice is set out in clause 81, which will require the CQC to specify that significant improvement is required, the services covered by the notice, the CQC's reasons for requiring improvement, and the time in which the necessary improvements are to be made. The problems facing individual trusts in the areas where they need to take action will therefore need to be made entirely clear by the CQC in an open and transparent way.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): Could the Minister clarify the thinking on separating out the quality and financial aspects of any notices given?

Dr Poulter: The amendments would potentially make the job of the CQC, Monitor and the TDA more difficult. We want to bring approaches to quality of care and sustainability into a single failure regime. I think we would all agree, following the Francis report, that it is inappropriate to look at a trust purely through the prism of financial sustainability; as important, if not more, is that quality of care is the driver for rapid action. The clauses set out mechanisms by which the Care Quality Commission, if it has concerns about a breach of fundamental standards of care or other serious concerns about care failings at a trust, can act promptly and effectively. They also bring together the role of the TDA and Monitor as regulators to ensure that they work with trusts and foundation trusts and that trusts work with local commissioners to respond rapidly to the concerns raised by the CQC, and then further inspections can take place as appropriate. The aim is to bring together regulators that previously worked in a disparate manner, so that they have a greater focus on the quality of care, which I believe we all support.

Grahame M. Morris (Easington) (Lab): Can the Minister explain why he opposes the idea of making a statement to Parliament? He has indicated that an individual trust could be faced with a TSA on the grounds of financial pressures and clinical outcomes, but also the impact on neighbouring trusts. Why is he opposing the Opposition amendment to make a statement to Parliament, so that Members representing neighbouring trusts could scrutinise that decision?

9.30 am

Dr Poulter: The hon. Gentleman may inadvertently be conflating clause 81 and clause 118, which deals with the process for trust special administration, which we will deal with later. It is important. I am sure we have all noticed that in the past the CQC has consistently raised concerns about quality of care at trusts, but it has sometimes taken many years for trusts to respond adequately to those concerns. This part of the Bill emphasises that quality of care, patient safety and preventing dangerous care and dangerous practice are so important that rapid action needs to be taken where appropriate. That is why we have a care quality regulator to take that action and ensure that where rapid action needs to be taken to protect patients, Monitor and the TDA comply with that approach.

We should also be clear that primary responsibility for addressing the problems facing an individual trust must remain with that trust. As I outlined in my response to the hon. Member for Oldham East and Saddleworth, it is not for the CQC simply to dictate solutions, but these amendments would require it to get dangerously close to that by requiring it to set prescriptive criteria

for the trust to meet. That may not be the intention behind the amendments, but they run the risk of centralising responsibility for quality and deterring trusts from finding the most appropriate solution for local circumstances. I hope hon. Members accept that the amendments potentially create a tick-box mentality—the very mentality we are trying to move away from in the wake of the Francis inquiry. We need a qualitative clinical judgment to be involved in the CQC assessment. It is not for Whitehall to dictate a one-size-fits-all approach to inspections.

Mr Reed: I have sympathy with the aim and direction of the clause, but we are seeking the ability for local clinicians to work with CQC inspectors at the earliest possible opportunity to establish what kinds of qualitative and even quantitative improvements they need to make. It is not a tick-box mentality, which he rightly warns against, but a tailored prescription for achieving faster local levels of improvement.

Dr Poulter: I accept the spirit in which that intervention was made. It is very clear, though, that the requirements set out here are initially for the CQC. If it is concerned about a breach in fundamental standards and it recognises that significant improvement in the quality of care is required, or there are other concerns, perhaps beyond fundamental standards—perhaps in poor clinical governance of a trust—such that significant improvements need to made, then a trust or a foundation trust will be required under the warning notice to make significant improvements. These will be labelled against specific failings in the quality of care, which will be set out in that warning notice.

The CQC will then reinspect at the end of a period after that warning notice has been issued and significant improvements have been detailed. It will be for commissioners and the trust to work together with the regulator, be that the TDA or Monitor, to ensure that appropriate action is taken. The CQC will then reinspect against the area set out in the warning notice so that there will be clarity for the trust. This also allows, very importantly, for the discretion of the chief inspector of hospitals or his team to make sure that this does not become a tick-box exercise.

Paul Burstow: The Minister has just referred to the chief inspector and the discretion he will have. The Bill does not remove from the Care Quality Commission its enforcement power in, for example, closing a ward. It does cast some doubt as to whether that route would generally still be available to a chief inspector should he think the matter warranted that level of early, urgent intervention. Will the Minister tell us, given that that power will remain in statute, whether it is still a power that a chief inspector can use, without reference to this route through to the trust special administration?

Dr Poulter: I can certainly reassure my hon. Friend that the powers of the CQC remain, in that the CQC has other powers to issue notices and raise concerns over the quality of care at a trust or a foundation trust. These measures will allow the identification of where significant improvements in the quality of care are needed due to breaches in the fundamental standards of care. If there are concerns that the quality of patient care is dangerously poor or that there are significant failings in care, a warning notice will be issued, which will allow a more rapid approach to be taken. The CQC can then re-inspect to ensure that local commissioners work with the trust, the board, the TDA and Monitor, and put in place the right measures to address the failings. In my view, that is a proportionate and appropriate means of dealing with failings of care. Of course, the CQC has other mechanisms for dealing with other issues, which may be appropriate for other providers. If it would help my right hon. Friend, I am happy to write to him with the details of those mechanisms.

Paul Burstow: I am grateful for that offer. It would be helpful to understand how the new regime that the Bill will put in place will fit with the old regime. In that letter, perhaps the Minister can give examples of circumstances in which the power to close a ward could be used without reference to the new arrangements in the Bill.

Dr Poulter: I am happy to write to my right hon. Friend to give him that assurance, and I hope he is broadly reassured by what I have said today. It is clear from our discussion that this is a complex area. We all want to ensure that high-quality care is delivered and that providers are held to account when there are failures in care. I am happy to write to my right hon. Friend to reassure him about the issues he raised about independent social care. I am pleased that he is broadly happy with what I have said today, and I hope that my further reassurance will be helpful.

These clauses are about ensuring that we can tackle quality failures in trusts. We have listened to the concerns raised in the Francis inquiry about serious failures in care in trusts and foundation trusts. We must ensure that we have a more rapid process for protecting patients against failures in care. We are taking a proportionate approach and ensuring that we have a framework that allows proportionate clinical judgment on the ground. We must have clinical leadership and inspections to ensure that trusts are held to account and that rapid action can be taken in the best interests of patients. For those reasons, I urge the Members to consider withdrawing their amendments.

Paul Burstow: I am grateful to the Minister for his reply and for his offer of a clarificatory letter. I agree that our goal is to avoid terrible failures in safety and quality, but I still have doubts about whether the Bill will create a single failure regime. Monitor will have the role of determining whether there are financial failures, and the Care Quality Commission will still have the role of determining whether there are quality failures; it is merely that they will both use the same club to enforce their will. The issue is whether the club will be appropriate in all circumstances.

Dr Poulter: If my right hon. Friend examines the clauses in detail, he will see that although Monitor is a financial regulator of trusts, the Bill acknowledges the findings of the Francis report, which highlighted that regulation needs to be brought into a single failure regime. Monitor will no longer only have a role in financial regulation; the clauses will require it to ensure that quality failures are addressed.

Paul Burstow: That is helpful. I can see an evolution taking place. We may not reach the end point of that evolution, but it is interesting. I am reassured about how clause 81(5) will allow the commission to issue guidance. That is useful. I am also reassured about the eminent gentleman who currently occupies the role of the chief inspector. The Minister is absolutely right that we can have considerable confidence about that. We are, however, designing a system that will remain when he is no longer the chief inspector; it is designed to be permanent and effective, whoever holds that role. I hold Sir Mike Richards in high regard, but he will not always be in that role and we need to keep that in mind when testing these arrangements.

My final point to the Minister is that we are making a number of very good changes to the Care Quality Commission's role in this legislation, such as the new chief inspectors, the new inspection regime and the fundamental standards—all wise, necessary changes—and the CQC already has an enforcement power. That, however, poses the question why the opportunity has not been taken to allow the changes to bed down before adding anything else by way of enforcement.

I am encouraged by what the Minister said, particularly with regards to the correspondence: I look forward to seeing that letter. The amendment was designed to probe the Government's intention, put some points to the Minister and listen to what he had to say. I do not intend to press the amendment but others may wish to press theirs.

On the procedure, Mr Rosindell, at an earlier sitting I withdrew my amendment and that seemed to cause some confusion as to whether other amendments could then be pressed. May I seek your guidance? Do I withdraw my amendment new, or should I keep it live? If I withdraw my amendment, can another be moved in its stead?

The Chair: The advice is that you can withdraw yours now.

Paul Burstow: Excellent. On that basis, I beg to ask leave to withdraw the amendment.

Mr Reed: I look forward to receiving the letter that the Minister will provide to the right hon. Gentleman, as does the rest of the Committee.

Amendment, by leave, withdrawn.

Clause 81 ordered to stand part of the Bill.

Clause 82

Imposition of licence conditions on NHS foundation trusts

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

Mr Reed: The clause facilitates the imposition of licence conditions on NHS foundation trusts and extends Monitor's powers to impose additional licence conditions on a foundation trust, which the Opposition welcome. My major concern, which we will consider more fully later, relates to the speed at which Monitor will work. We are all keen to ensure that speedy and appropriate action is taken, but we surely want to guard against a process that could lead to a forced rush in introducing the trust special administrator, and we can do that by focusing downstream. Clearly, the imposition of licence conditions is intended to be a pre-TSA warning system, but how much of an early-warning system is that? What are the time scales between the imposition of licence conditions and either the lifting of those, or the beginning of the TSA process, and where is that made explicit? Do the Government intend to produce guidance on that and, if so, will that happen before Report?

If 20 or more trusts are in serious financial difficulties, with the possibility of that number increasing as demand increases and supply fails to catch up, and if trust special administration is truly to be a regulation of last resort, the process that leads towards the imposition of licence conditions needs to be crystal clear, not just for effective and expedient regulation, but to maintain care standards. Will the Minister therefore make explicit in guidance the warning signs leading up to the imposition of licence conditions, and the time scale over which those conditions may be satisfied and then lifted, extended, or failed?

9.45 am

Dr Poulter: I will address directly the points raised rather than speak to the clause, which we largely covered in the previous debate.

If the CQC recognises that a trust requires significant improvement, it will issue a warning notice, given that, in some trusts, failings of care are so extreme or severe, and thus potentially damaging or dangerous to patients and patient care, that prompt action needs to be taken. The hon. Gentleman talked about the method of last resort, and the warning notice will also indicate that the trust special administration process could be used, if required, which will make trusts sit up much more quickly and take on board the concerns raised by the CQC. One of the concerns highlighted by the Francis inquiry was that trusts have not always taken the CQC as seriously as they need to. This measure will be used as a recognition that significant improvement is required and that trust special administration could ultimately be put in place, meaning that improvements need to be made.

The first step towards those improvements will be achieved through a trust working, as at present, with local commissioners to address care quality issues. Monitor or the TDA will oversee that process for the trust or foundation trusts. Following that process, the CQC will reinspect to see whether improvements have been made broadly in line with what was outlined in the warning notice. It may well be the case that if there were still fundamental concerns, the trust special administration process would need to be triggered. Alternatively, it could be that more time would be required. It will be for the CQC to set time limits that are appropriate to what it finds and what issues have been raised in the warning notice. That is a matter of clinical judgment, so it would be very difficult for hon. Members or Whitehall to be prescriptive about that.

The hon. Gentleman asked about the timetable for setting out the framework for how the process will work, Monitor will update its guidance for health care providers on licensing regimes in the light of the Bill.

There is no set timetable for that at the moment, but once the Bill has been passed, the framework will be laid out. As I outlined when speaking to the previous group of amendments, a process is being lined up for Monitor, the TDA and the CQC to work out joint guidance for trusts and foundation trusts, so I hope that the hon. Gentleman finds that reassuring.

Question put and agreed to.

Clause 82 accordingly ordered to stand part of the Bill.

Clause 83

TRUST SPECIAL ADMINISTRATION: APPOINTMENT OF ADMINISTRATOR

Mr Reed: I beg to move amendment 146, in clause 83, page 74, line 32, at end insert—

'( ) Relevant Local Authorities.'.

My comments will not focus on the merits or otherwise of clause 118, which was introduced during the Bill's passage through the other place. I am sure that many Members have been vexed by that clause, and I am certain that it will require wider scrutiny on Report. I will make that point again when we get to that clause.

Amendment 146 would rectify what I can only assume was an oversight by the Government. It seems that the legislative intention does not match the aspiration contained in the language in the Bill.

I shall briefly explain what the amendment would achieve before explaining why it is essential that it is incorporated in the Bill. It would amend clause 83(4), which lists with whom the CQC must consult before the appointment of a trust special administrator.

Members will have noticed that explanatory notes on this measure state:

"Before requiring Monitor to make an order for the appointment of the administrator, the CQC will need to consult first the Secretary of State and Monitor, and then the foundation trust, the NHS Commissioning Board and any other person, for example a clinical commissioning group, to which the foundation trust provides services".

We tabled the amendment so that the Care Quality Commission would be required to consult local authorities when appointing a trust special administrator. Such an approach is essential to promote a collegiate attitude towards the provision of services in any specified local health economy, as well as to aid the integration of services in commissioning and to smooth the progress.

The trust special administration process, as it currently stands—before the Bill significantly expands the role—is concerned with the provision and quality of health care services at an individual trust. Building on that, the Government have been eager to adopt the language used by my right hon. Friend the shadow Secretary of State for Health in his call for more integration between health service providers, commissioners and local authorities. It is clear from our previous debates that there is general agreement that better integration is a key cornerstone in improving health outcomes for patients.

With that in mind, it is crucial that local authorities are involved at all levels of commissioning and when reconfigurations are necessary. No one on this side of the Committee will deny that difficult decisions have to be taken about services, but we will always insist that they are taken with the interests of the patients at their core. Surely that is the aim of every single hon. Member. Fundamentally, decisions must always be clinically driven.

To provide effective commissioning, local authorities must be involved, and they must also be involved in the process of appointing a trust special administrator. As the health and well-being of individual patients is the driving principle underpinning health service provision, effective consultation must sit at the heart of the process, which involves consulting all relevant partners. That is clearly a must with regard to ensuring the improvement of care.

The amendment was drafted with all that in mind. The wording was chosen to ensure that, in two-tier systems, both councils would be involved. Our amendment would put a statutory duty on the Care Quality Commission to consult local authorities when it seeks to instruct Monitor to appoint a trust special administrator within the locality of that authority. The Government may well contend that nothing in clause 83 would preclude consultation with local authorities and that subsection (4) allows that, given that it states that the commission must consult

"any other person to which the trust provides services under this Act and which the Commission considers it appropriate to consult."

That is all well and good, but it does not go far enough to ensure that integrated practices are pursued, maintained and enforced.

I will be extremely grateful if the Minister sets out in some detail the safeguards that will be in place to ensure that those who should be consulted are consulted, even if the Care Quality Commission deems it unnecessary to do. I also ask him to go into detail about why local authorities have not been included on the list of statutory consultees. It seems a glaring omission, especially in light of the Lewisham judgment.

I do not accept that the Government have already covered this point by giving discretion to the Care Quality Commission because of the lack of clarity implicit in the clause. Even the explanatory notes make it plain that local authorities are not included. The example cited to demonstrate the CQC's flexibility is inclusion for the clinical commissioning group, which is obviously critical, but I am worried by the lack of reference to councils, which reflects an emerging theme of our discussions to date. The Government's approach to aspects of the Bill shows the real tensions between the principles of localism and power at the centre.

There is nothing destructive or complicated about including local authorities within the clause. The amendment would simply extend the statutory duty to consult to them, rather than leaving consultation to the judgment of the Care Quality Commission. I urge the Government to learn the lessons of the Lewisham judgment. I am sure the Minister will agree that it is imperative that local decision makers are involved at all stages of the appointment of a TSA. We want further clarification from the Government about how the CQC should judge who is a relevant consultee, and we want to know how the Government drew the line at the list of consultees in the Bill, from which local authorities have been excluded.

Although I would be absolutely delighted if the Government were to accept the reasoning behind the amendment and to support it, what is really essential is that they undertake to produce guidance on who should

[Mr Jamie Reed]

be consulted when the CQC considers instructing Monitor on the appointment of a trust special administrator. They should also ensure that it is clear in the guidance that the Care Quality Commission must fully consult relevant local authorities. If the Minister can satisfy that request, I will gladly consider withdrawing the amendment.

Dr Poulter: Members may find it helpful if I briefly outline the stages of the single failure regime and the consultation processes that may ultimately culminate in applying the trust special administration regime. We briefly discussed that when we were dealing with clause 82.

The failure regime will give regulators clearer roles when tackling failure. The CQC will focus on exposing problems and requiring action, while Monitor and the NHS Trust Development Authority will focus on intervening, if a poor-performing provider is unable to resolve the situation, working with local commissioners. The CQC will be able to highlight problems and require improvement at NHS trusts and foundation trusts through a new warning notice that will require the trust to improve within a specified time.

Primary responsibility for ensuring that there is a comprehensive response to the notice will remain with the individual trust, working with its commissioners. However, if the trust is incapable of responding, Monitor or the TDA may use their intervention powers to secure the necessary improvements. The importance of regulators' ability to take rapid and decisive action on quality failures was highlighted by the Francis report, so there is no requirement for consultation or a right of appeal in response to a CQC warning notice, or intervention by Monitor or the TDA.

At the end of the period specified in the notice, the CQC will be required to review whether the necessary improvement has been made. If that is not the case, the CQC must consider what further action is required, including trust special administration which, as hon. Members will be aware, was introduced by the previous Government through the Health Act 2009, which was subsequently amended by the Health and Social Care Act 2012.

Under clause 83, Monitor will be able to put a failed foundation trust into trust special administration if it becomes clinically unsustainable for reasons of patient safety, whereas it can currently do so only in the case of financial insolvency. NHS trusts can already be put into special administration in the interests of the health service, so the Bill brings foundation trusts into line with NHS trusts for the process of triggering special administration as a result of a failure in care quality. The clause also allows the CQC to direct Monitor to place a foundation trust into trust special administration on quality grounds if that is necessary.

Before placing a foundation trust into TSA, the CQC must consult the Secretary of State, Monitor, NHS England and those that commission services from the foundation trust that the CQC considers it appropriate to consult. Such bodies could include local authorities that commission health services from the foundation trust. This appropriateness test, rather than a mandatory requirement to consult, is proportionate and allows for rapid action when required properly to address serious failures in the quality of health care and patient services. We have already committed in the other place to make equivalent provisions for NHS trusts by updating the directions to the TDA that came into force on 1 April 2013 when this clause of the Bill is commenced.

The decision to appoint a trust special administrator at a foundation trust is not a matter for public consultation. The CQC will be able to compel Monitor to initiate trust special administration only if a foundation trust has experienced a serious failure of quality, when it will be important to minimise the scope for delay. That is why the requirement to consult at that stage is confined to the Secretary of State and those regulators and commissioners that have both a significant stake in the foundation trust and a statutory role in the TSA process.

Amendment 146 would impose a blanket requirement for the CQC to consult "relevant local authorities" before it could compel Monitor to initiate TSA for a foundation trust, which could lead to unnecessary delays. I am sure that we are all concerned about protecting patients and safeguarding high-quality patient care, in recognition of the challenges and difficulties highlighted by the Francis report. That is why it is important that we minimise delay in the process.

I do, however, agree with the hon. Gentleman that local authorities have an interest in the future of their local hospital. Once appointed, the trust special administrator is under a legal duty to undertake a consultation on its draft recommendations about the future of the failing foundation trust and its services, which includes a duty to consult the public so that anyone with an interest may give their views. The Bill extends the time the administrator has to produce its report and consult locally, and we will come back to these matters when we debate clause 118.

Local authorities will therefore, at the appropriate point, have an opportunity to be involved in developing proposals for the future configuration of foundation trust services in their area. To return to the duties on the CQC to consult before requiring Monitor to appoint a TSA, the Bill already provides for the CQC to consult commissioners when appropriate, and those commissioners could include local authorities that commission health services from the local foundation trust. Taken with the requirements for the TSA to consult on its draft recommendations, that means that amendment 146 is unnecessary, as the views of the local authority will be sought at the appropriate point and taken into account by the TSA in either instance, should the trust special administration process be triggered. I hope the hon. Gentleman is sufficiently reassured that he will withdraw the amendment.

Mr Reed: I have listened with interest to the Minister, and I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

10 am

Mr Reed: I beg to move amendment 142, in clause 83, page 75, line 3, at end insert—

'( ) Upon the appointment of the Trust Special Administrator in line with the provisions set out in this section, the Secretary of State must prepare and lay before each House of Parliament a report which sets out the requirement for the appointment, the

criteria for the role and the extent to which the appointment satisfies those criteria.'.

Thanks to a delightful quirk of the Committee system, I had to speak to amendment 146 for the best part of 10 minutes, and now rise to discuss amendment 142, which would add to clause 83.

The amendment would place a duty on the Secretary of State to make a statement to the House of Commons in the circumstances described. There are two main reasons behind it, concerning the responsibility of any Secretary of State regarding the provisions of the clause. First, it would make public the role of the Secretary of State in the consultation process—something I spoke about earlier. Secondly, it would give hon. Members the chance to scrutinise the appointment of the TSA and provide an arena and opportunity to address any genuine grievances and provide relevant reassurances. The earlier concerns are addressed, the quicker the process will be and the more robust the recommendations of the TSA.

We all have experience of how this place operates. None of us, if we are honest, likes being governed by written ministerial statement. Nobody looks good sneaking out a WMS on a one-line Whip on a day the House rises. That only invites urgent questions and hostility. Every Government, of every colour, are guilty of that practice.

With regard to the role of the Secretary of State in the consultation process, unlike local authorities, the Secretary of State is listed under subsection (4) as a statutory consultee. Indeed, the Care Quality Commission cannot seek to consult even with the trust in question before the Secretary of State has been involved. There is a clear implication that the Secretary of State has a key role. With the CQC legally obliged to approach the Secretary of State with its intention to instruct Monitor to appoint a TSA, it could be thought that the Secretary of State had a de facto veto on any appointment of a TSA.

It is the word "consult" that leads to that conclusion, as it suggests an exchange of views on the validity of the action being taken by the CQC. The clause could quite easily use the word "inform" rather than "consult", so that the Secretary of State would simply be notified of the intention to appoint a TSA. The use of the word "consult" clearly suggests a degree of influence. I do not think that would strike a chord—at least not in public, with the Secretary of State's hands-off approach—nor would it chime with the principle behind clause 88, which we will discuss later. Is the Minister intellectually able to marry two contradictory principles? Given that the CQC will be legally obliged to consult the Health Secretary before it approaches other bodies, including the trust in question and NHS England, are we right to assume that the Secretary of State has more influence over the process than has been implied so far? That would have wide-ranging consequences in the context of clause 118, which we will discuss later.

As the Secretary of State is involved on some level in the consultation process on appointing the TSA, he or she will have some influence on the detail of such an appointment. Therefore, it is right that the Secretary of State should justify to Parliament the detail of the appointment, the reasoning behind it and the extent to which the appointment will satisfy those reasons. There should be an oral statement to the House in which the Secretary of State sits, accompanied by a written statement.

I think that we would all concede that the appointment of a TSA is now etched in the public consciousness as a bad omen, due to its recent haphazard application. We ought to understand the profound effect that the Lewisham case has had on public opinion, with regard to the introduction of the TSA and the use of TSA powers. The negative connotations associated with that mean that there will be great anxiety in communities—we all recognise that—and, in such times, members of the public approach their MPs, who will be compelled to act. Given that the Secretary of State will have the opportunity to discuss the appointment with the regulator, it is only right—and constitutionally just—that elected Members can relay their constituents' queries to the Health Secretary and that he or she responds.

We recently saw an unsatisfactory example of major service changes affecting Salford Royal hospital in the constituency of my right hon. Friend the Member for Salford and Eccles (Hazel Blears). She had not been informed by the Department of those changes and there was a statement or urgent question relating to that when she was half way from London to Manchester. We want to avoid that situation.

Given the significance of the appointment of a trust special administrator, it is essential that Parliament can scrutinise that decision. The amendment would not just apply a duty to the Secretary of State, but give Parliament an opportunity to fulfil a key duty: performing effective scrutiny. That can only benefit the Secretary of State, the affected trust, the community in which that trust is situated, neighbouring communities and the process and regime in general.

Finally, the appointment of a trust special administrator is extremely significant in a local health economy; as such, it requires serious consideration and effective scrutiny. Requiring the Secretary of State to relay the decisions and the reasons behind them to Parliament would ensure that the decision to appoint was understood to have due significance and would indicate the magnitude of the decision.

I have been particularly brief in my remarks, but only because I hope that the Minister can reassure me on some of the issues I have raised. Will he clarify the Secretary of State's role in the appointment of a trust special administrator? Will he also assure us that the Government will ensure that the decision to appoint will be properly communicated to Parliament and that hon. Members will have sufficient opportunity to scrutinise the decision? If he can give such assurances, there may be no reason to test the will of the Committee. I sincerely hope that he will give those reassurances in his reply and not rely on a written ministerial statement on a one-line Whip on the rise of the House.

Dr Poulter: I agree entirely with the hon. Gentleman and the Opposition that the appointment of a trust special administrator should be subject to a report laid before Parliament, as proposed in the amendment. The clause enables Monitor to make an order to authorise the appointment of a trust special administrator where it is satisfied that there is a serious failure by an NHS foundation trust to provide health care services of sufficient quality and that special administration is an appropriate solution. It also enables the CQC to require Monitor to make such an order when it forms that view.

[Dr Poulter]

If the NHS Trust Development Authority considers it to be in the interests of the health service, it can already advise the Secretary of State to place an NHS trust that it considers to be clinically and/or financially unsustainable into special administration. Provision for the CQC to trigger similar action in respect of NHS trusts will be made through directions to the TDA.

The amendment would require the Secretary of State to lay a report before Parliament following the appointment of a TSA in a foundation trust. Such decisions are taken by Monitor, which is already required to lay a report before Parliament setting out its reasons for the appointment under section 65D of the National Health Service Act 2006, which was laid by the previous Government. An equivalent requirement under section 65B of the 2006 Act applies to the Secretary of State when a TSA is appointed in respect of an NHS trust. Those requirements will apply, whatever the grounds for appointment of a TSA.

The arrangements for parliamentary oversight of TSA appointments remain as robust as those originally enacted in 2006 by the previous Government. The amendment is therefore unnecessary, as there is already a requirement for a report to be laid before Parliament when a TSA is appointed. I hope that that is sufficient reassurance for the hon. Gentleman to withdraw his amendment.

Mr Reed: Those were significant assurances and I will need to consider the detail in the 2006 Act. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 83 ordered to stand part of the Bill.

Clauses 84 and 85 ordered to stand part of the Bill.

Clause 86

Unitary board

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

Mr Reed: Clause 86, on appointments to the unitary board, relates to executive and non-executive members. My concern is, how will we guard against conflicts of interest of executive and non-executive members and will that be made clear in guidance at any stage? Is there a duty of candour—to coin a phrase—on executive members? Will the Government make it plain in any guidance they choose to lay before the House that conflicts of interest will be addressed and guarded against?

The Minister of State, Department of Health (Norman Lamb): I thank the shadow Minister for that question. It is clearly essential that conflicts of interest are avoided. There is no formal statutory duty of candour that applies to the Care Quality Commission; the duty of candour is to apply to providers of care. I am happy to write to the hon. Gentleman to confirm the process for the appointments of executive and non-executive directors of the CQC.

Mr Reed: I am grateful for the Minister's reply. I have precisely the same question about clause 87 and the appointment of chief inspectors.

Norman Lamb: Mr Rosindell, I am happy to confirm that my letter to the shadow Minister will deal with both issues.

Question put and agreed to.

Clause 86 accordingly ordered to stand part of the Bill.

Clause 87 ordered to stand part of the Bill.

Clause 88

Independence of the Care Quality Commission

Paul Burstow: I beg to move amendment 49, in clause 88, page 79, line 18, leave out subsection (4).

This amendment is one of a number intended, collectively, to restore the powers of the Care Quality Commission to review or investigate local authority social care provision or commissioning without first securing, singular or joint, Ministerial approval.

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

Amendment 126, in clause 89, page 80, line 20, at end insert—

'(2A) The Commission must, in respect of such English local authorities as may be prescribed—

(a) conduct reviews of the provision of such adult social services provided or commissioned by the authorities as may be prescribed;

(b) assess the performance of the authorities following each such review; and

(c) publish a report of its assessment.

(2B) Regulations under subsection (3) may prescribe—

(a) all adult social services or adult social services of a particular description; and

(b) all local authorities or particular local authorities.'.

Amendment 127, in clause 89, page 80, line 21, after 'provider', insert—

'other than the provision of adult social services'.

Amendment 128, in clause 89, page 80, line 23, at end add—

'(3A) The assessment of the performance of a provider of adult social services, in respect of that provision, is to be by reference to a quality standards framework, and indicators therein, to be developed jointly by the English local authorities and the Commission under arrangements to be established by regulations under this Act.'.

Government amendment 154.

Amendment 51, in clause 89, page 81, line 19, leave out '(5) Omit subsection (1A) of that section.'.

This amendment is one of a number intended, collectively, to restore the powers of the Care Quality Commission to review or investigate local authority social care provision or commissioning without first securing, singular or joint, Ministerial approval.

Amendment 50, in clause 89, page 81, leave out lines 16 to 18.

This amendment is one of a number intended, collectively, to restore the powers of the Care Quality Commission to review or investigate local authority social care provision or commissioning without first securing, singular or joint, Ministerial approval.

10.15 am

Paul Burstow: The amendments relate to issues that have come up throughout the Bill's consideration, in particular when we debated part 1. They pertain to the quality of the commissioning and how the public can be satisfied that it is doing what it is intended to do. They would ensure that people received good quality service and outcomes, in terms of the care delivered, the support provided and the arrangements made to secure their well-being under clause 1.

In the care and support White Paper, a number of organisations outside this House raised concerns about the Government's view of the CQC's role in ensuring that the quality of commissioning is maintained and, where it is poor, improved. There is a problem of fly-by-night, 15-minute contracting, where the focus is on task and finish, and on watching the clock because there is not enough time to do the job adequately. That has been a characteristic of poor commissioning practice for a long time. We in this place should make it absolutely clear that that is unacceptable and empower the Care Quality Commission to pursue commissioners who think that such practices are acceptable.

The Joint Committee raised concerns about that issue, which the Government took on board. They tabled amendments in the House of Lords to clarify that commissioners should take well-being into account, which was a helpful step in the right direction. It is therefore curious that during the consideration of the Bill in the Lords, the Government removed the backstop powers to undertake regular inspections. I think they did that because they took the view that the sector-led improvement processes that have been put in place are sufficient and that periodic reviews against a rating system are, to some extent, a tick-box approach that creates reaction and response by rote. They took the view that we need the inspectorate to genuinely engage with the way in which commissioning really works, which does not require a regular inspection of everyone, but targeted inspections of the commissioners who are clearly not doing the job well. I tabled the amendments because we need to ensure that the CQC has the power and independence of action to make decisions on the basis of evidence that it gathers from inspections of providers that the problems in a particular set of providers are caused by bad commissioning practice or poor procurement arrangements.

Anne Marie Morris (Newton Abbot) (Con): I am pleased that the right hon. Gentleman tabled the amendments. I share his concerns about the changes made to the Bill in the other place, because I have personal experience of the fact that we need to ensure that commissioners are held to account. I agree that limiting the CQC's capacity to intervene to circumstances where the Secretary of State gives permission does not give it the necessary rigour. I share the right hon. Gentleman's concern that the improvements in the system will not be enough.

Paul Burstow: I am grateful to the hon. Lady. She has been clear about her concerns throughout the Committee, and I welcome her support for this group of amendments.

Let me quickly talk about what the amendments would do. Amendment 49 would restore the CQC's ability to investigate social care provision from the perspective of the local authority without the agreement of the Secretary of State. Amendment 50 would restore the Care Quality Commission's powers to instigate special reviews of local authority practices with regard to social care provision without the agreement of the Secretary of State, which would place it on a par with the powers that apply to health provision. Amendment 51 would restore the Care Quality Commission's powers to conduct special reviews of local authority practices in regard to social care when it considers there to be

"a risk to the health, safety or welfare of persons receiving health or social care",

without seeking the permission of the Secretary of State. The amendments would ensure that the CQC has the right range of powers to deal with flaws in commissioning.

Jim Shannon (Strangford) (DUP): Will the right hon. Gentleman assure me and others that the amendment will mean that the families who report their concerns will have them considered by the body responsible? I am always conscious that whenever people come to deliver care to elderly relatives in their homes, there are things they neglect to do. One example would be the making of beds for someone with problems with both hands who cannot do so themselves. There are wee, small things that families can see, but others cannot. Will those concerns be considered?

Paul Burstow: This group of amendments does not speak directly to that issue, but the hon. Gentleman is absolutely right to question the extent to which the concerns—not just of family members, but of whistle-blowing members of staff—are taken into account and acted upon by the Care Quality Commission. The CQC was rocked to its foundations by Winterbourne View and the lack of focus on whistleblowing and so on. Subsequent to Winterbourne View, the CQC established a much bigger team in its offices in Newcastle to enable it to be much better and more sensitive to calls of that sort. I hope that is the case, although I look forward to the Minister's reassurance—it is him we want to reassure us, not me.

This debate gives me the opportunity to pay tribute to Leonard Cheshire Disability, the charity that has been drawing attention to this issue. It conducted the survey that found that 60% of local authorities commission flying visits of 15 minutes or less and that the proportion of such visits had risen by 15% over the last five years, so there is an unacceptable trend. I hope the Minister can say something about that. I know that both the Minister and the chief executive of the Care Quality Commission are concerned about this, because they have made clear on the record their desire to challenge such practices.

Finally, I put it to the Minister that at the very least we need the Care Quality Commission to conduct a themed inspection of sector-led improvement, to satisfy ourselves that sector-led improvement is working. I say that as the former Minister who took the decision to put resources behind the establishment of sector-led improvement. If I were a Minister now, I would want to be satisfied that that was working and I would want the public to be satisfied. A themed inspection would be a good way to establish whether the programme was working well and, where it worked well, to ensure that that good practice was transferred to places where it

[Paul Burstow]

was working less well. That is what a good themed inspection should do. I also hope that the Minister can take this opportunity to reassure the Committee and the many organisations in the Care and Support Alliance and others that the Government want the CQC to play a role in this area and that he will set out how that role is to be fulfilled.

Mrs Emma Lewell-Buck (South Shields) (Lab): My amendments are in a similar vein to those I tabled to clause 27. Their purpose is to strengthen safeguarding, based on my personal and practical experience. Amendment 126 would reinsert subsections of the Bill which were unfortunately removed on Report in the other place. Those subsections required the Care Quality Commission to review and assess local authorities and their provision of adult social care.

A number of peers in the other place expressed their disappointment at the removal of these subsections, as did charities such as Leonard Cheshire Disability, as they believed that their removal weakened the CQC's ability to challenge poor commissioning and delivery of care. As was rightly pointed out at the time, this should be an essential function of the CQC. I am concerned that, without regular monitoring by the CQC, more and more examples of inadequate care, neglect and abuse will go undetected.

The current culture in adult social care is one of sector-led improvement, with CQC oversight having been played down since 2010, when the Government announced the cessation of annual performance assessments. What that means in practice is that the CQC no longer inspects local authorities' commissioning practices, even though the legislation remains in place for it to do so.

The last annual performance assessment process undertaken in my local authority was in 2009. For four years, we have operated under sector-led improvement, a model in which local authorities on a regional basis voluntarily subject themselves to peer reviews to assess each other and work supportively and collaboratively. Although that approach may have some advantages, accountability is not one of them. The fact is that local authorities feel vulnerable, which has fostered collusion. If a local authority is alerted to poor practice in another local authority with which it has been working closely and collaboratively, it is highly unlikely to expose that poor practice. Local authorities are more likely to give each other leniency when it comes to making improvements—leniency that the CQC would not have given them—and such leniency may lead to harm. I would be grateful if the Minister would inform me how many local authorities have been subject to a peer review since the change was announced.

Another negative result of sector-led improvement was highlighted only last year by the chief executive of the CQC. Although he acknowledged that sharing and learning can help to improve a service, he queried how open local authorities that were failing, or on the cusp of failing, would be to volunteering themselves for review. Either way, I believe that sector-led improvement is fraught with problems. Because the CQC has not been allowed to inspect and assess local authorities and their commissioning practices, an unaccountable sector has emerged in which failure is swept under the rug and whistleblowers feel unable to come forward.

Meg Munn (Sheffield, Heeley) (Lab/Co-op): My hon. Friend is making a powerful speech, because she has such recent experience of the matter. Does she agree that when it comes to the care and protection of vulnerable people, any delays in dealing with a situation are of concern, and that governance and accountability are fundamental in reassuring families and other carers that vulnerable people will be properly looked after?

Mrs Lewell-Buck: I agree entirely with my hon. Friend. I have experienced situations in which there has been delay, which has caused harm and distress not only to those receiving care, but to their families. In addition, 15-minute visits for personal care are becoming the norm, and poor treatment is going unchecked. Ultimately, those who receive care are the ones who suffer. I am puzzled about why the Government saw fit to remove those subsections of the Bill, which they appeared to support when they introduced them. In April last year, the Minister of State in the Department of Health suggested that he supported the reintroduction of CQC monitoring for councils' commissioning practices. I would be grateful if the Minister could explain in his response what has changed the Government's thinking.

The Bill now allows the CQC to conduct reviews only under special circumstances with the permission of the Secretary of State. Although that power is welcome in cases where widespread and systematic failure has been identified, it means that low-level or isolated cases of failure are unlikely to be picked up on. Without the prospect of routine inspection, local authorities may well become complacent and allow standards to fall.

Amendments 127 and 128 are essentially probing amendments that relate to the monitoring of care homes. As we know, the CQC has only so much capacity to inspect services. That has been seen with cases such as Winterbourne View, where abuse went undetected. When CQC inspections take place, they are often desktop exercises, because the CQC does not have the capacity to conduct thorough and in-depth inspections. The amendments would require local authorities to develop a robust and thorough quality standards framework for monitoring the care homes in their areas. In my borough of South Tyneside, I implemented such a model and it drastically improved the quality of care in our homes. The care home services commissioned were monitored by an in-house quality contracts control team, which regularly checked that providers were meeting their obligations, inclusive of service user feedback. Our model ensured that care homes were subject to much closer scrutiny than had previously been the case. The CQC cannot be expected to carry out comprehensive annual inspections of all care homes across the country, and local authorities need to assume some responsibility.

10.30 am

Norman Lamb: The hon. Lady says she has concerns about the Care Quality Commission not having the capacity to undertake proper inspection of providers, yet at the same time she argues the case for an enormous amount of extra work for the Care Quality Commission

in undertaking periodic continuous reviews of local authorities. I do not understand how both can be right. Surely the best thing is to ensure that the Care Quality Commission has time to focus on rigorous inspections of providers.

Mrs Lewell-Buck: I am explaining that the Care Quality Commission can do reviews of local authority care homes but cannot do in-depth reviews. The model I propose is one we have used in my local authority and which gave an extra layer on top of the Care Quality Commission.

I recognise that there may be a concern about bias, but the CQC oversight outlined in amendment 126 would create a further layer of accountability which would motivate local authorities to be appropriately rigorous in their checks and tackle internal failings. It is of course in a local authority's own interest to ensure that the services they commission are good value for money and to avoid expensive and reputationally damaging safeguarding investigations. This in itself should be a powerful motivator for authorities to deal with inadequate services, but in the event that this does not happen, the threat of CQC inspection provides a further check.

Our model only covered those we commissioned with, but that was because we commissioned with every care home in the area. The quality monitoring was going to be rolled out to learning disability, mental health and physical disability residential homes as well as domiciliary care. There is no reason why local authorities cannot provide this monitoring for all homes in their area regardless of commissioning. It would be worth their investment if safeguarding alerts were minimised and scandals avoided. This structure has proved very successful in my local authority, where in the past we experienced safeguarding scandals such as the one at St Michael's View care home.

Andrew Griffiths: The hon. Lady gave a detailed example of how this has been working in her constituency. Will she give us an idea of the costs involved? Obviously, any extra system comes with additional burdens and costs.

Mrs Lewell-Buck: I do not know the exact cost because different authorities have copied this model, taken it on and used existing teams or existing contract monitoring teams. It varies from area to area so I would not like to give a cost.

Meg Munn: Although I understand that we have to look at the cost issue, I understand from my hon. Friend's explanation that being proactive in ensuring good care stops the process of things getting worse and scandals occurring. In my experience, when something that has gone wrong is investigated it takes an enormous time. It has to be done and it takes away from having that work done up front. I am not saying that there might not be an additional cost, but I think that this is both the right thing to do and likely to have cost savings too.

Mrs Lewell-Buck: My hon. Friend's intervention leads nicely on to what I was going to explain. If this model had been in place in one of our care homes where 16 residents died, those deaths could have been avoided. Whatever the cost of that safeguarding investigation, it is surely in a local authority's best interest to have some checks and safeguards in place. As I said, this has dramatically improved care services in my constituency. I believe that this needs to be taken forward, as do other local authorities that have developed the model and report its benefits. The problem is that the implementation is piecemeal and it depends on which area of the country people are in. I hope that the Minister will agree that the model is worthy of some consideration and debate.

In my authority, people died from horrendous and sustained abuse before the service was overhauled. I do not want other authorities to wait until then to do something. I do not want anyone to have to suffer in the way those 16 residents did. I know that the Minister cares deeply about safeguarding and I welcome the steps taken thus far in the Bill, but, for me, it simply does not go far enough. I know that the Government and the Minister do not want to be too prescriptive, but we owe it to all those who have suffered or are suffering harm to make the system as foolproof as possible. I would welcome the Minister's comments and views on the amendments.

Mr Reed: Given that the Opposition's amendments seek to achieve the same ends as those tabled by the right hon. Member for Sutton and Cheam, members of the Committee will not be surprised to hear that I agree with a substantial amount of what he has had to say on the matter.

To ensure that no detail is left out, I will speak about the clause generally—the principles behind it—and I assure the Committee, and indeed the Government, of the Opposition's support before speaking about each individual amendment. I find that, where legislative scrutiny is concerned, it is always better to err on the side of thoroughness. I am sure members of the Committee will appreciate that, given today's schedule and the groupings on the amendment paper.

A strong effective regulator is as essential in the health care system as it is in any other sector. Only through thorough and effective monitoring and enforcement can patients have confidence in the services they receive. That is why, in the Health and Social Care Act 2008, the Labour Government legislated for the formation of the Care Quality Commission, which was brought into being in the year after the first ever independent regulation in the national health service.

Under section 3 of the Health and Social Care Act, the main function of the CQC is,

"to protect and promote the health, safety and welfare of people who use health and social care services."

That aim that should underpin everything that we all aspire to achieve in Committee. I am sure that the principle behind ensuring the regulator's independence receives the Committee's full support. However, there are anomalies in the Bill and obvious omissions, on which the Opposition seek clarification. The amendments would further ensure the independence of the CQC, as well as go some way towards improving health and social care provision. There are glaring examples in clause 88, which some of the amendments seek to amend, and there are further examples in clause 89 that we will get on to later.

[Mr Jamie Reed]

On amendment 49, the Opposition clearly share the concern of the right hon. Member for Sutton and Cheam regarding the place that aspects of the clause would leave the Care Quality Commission in with regard to the inspection of local authority provision for social care. It cannot be right for the Government to introduce a Bill that they claim will improve integration between health and social care services and strengthen the independence of the CQC, while legislating that the health regulator cannot review or investigate local authority social care provision or commissioning without first securing ministerial approval.

Norman Lamb: I want to be absolutely clear that, when the Care Quality Commission wants to inspect local authority provision of social care where it is a registered activity, there is absolutely no need for Secretary of State approval. It can inspect a local authority provided service just as it can inspect any other service. Perhaps the hon. Gentleman misunderstands the provision, but there is no need for such approval when inspecting local authority provision.

Mr Reed: I am grateful for that useful clarification, but I am afraid that I share the view of the right hon. Member for Sutton and Cheam that the omissions in the clause move in the opposite direction to the stated aims in clause 1 and part 1. Such a course of legislative action makes integrated commissioning harder and weakens the principle of regulatory independence. I hope that, when the Minister responds, he can give further assurances that that will be rectified.

Amendments 126 and 127 would take the same remedial action in respect of the counter-intuitive prescription that is apparent in the clause as it stands. Amendment 128 would go a long way towards improving the inspection process for local authority social care provision. It would ensure that local authorities and the Care Quality Commission could work in partnership to bring forward a quality standards framework and the indicators that that would be judged by. The fact that those would be developed through strong communication would ensure a much higher chance of universal support and more committed buy-in for the system.

Will the Minister explain how the Bill encourages strong communication? Why does he believe that the Care Quality Commission's needing to get ministerial approval to inspect local authority provision will help achieve the aim of my hon. Friend the Member for South Shields, notwithstanding his previous clarification? The idea that the Care Quality Commission is becoming independent in how it assesses, reviews and rates hospitals does not chime with the shackle placed on it with regard to local authority provision of social care. The Care Quality Commission must be free to inspect what it deems right to inspect. If it decides that it needs to review social care provision under a local authority, the Secretary of State or other Ministers should not have a legal right to stop them. If that is the intention of this part of the Bill, will the Minister explain why?

I hope that the right hon. Member for Sutton and Cheam will test the will of Committee—I have tried this tactic several times—because it is clear that he has cross-party support for his position. However, my main hope is that the Minister will provide robust reassurances that the clause will not inadvertently impede the actions of the CQC or its ability to inspect what it needs to inspect, where it needs to inspect, and to determine its reasons for inspecting.

Norman Lamb: I want to start by addressing a comment made by the hon. Member for South Shields. She said that her fear was that there would be "more examples of poor care" going undetected. If that was the case, it would obviously be of enormous concern. However, the whole purpose of what the Government are doing is to make that much less likely to happen, by introducing much more robust inspections of providers—whether in social or health care—with teams of inspectors who have expertise rather than generalists. That is a massively important reform, including the introduction of a chief inspector of social care and ratings of providers. I therefore think that the risk of poor care going undetected diminishes rather than increases as a result of the steps that the Government are taking.

Debbie Abrahams: Earlier, we talked about the importance of developing a culture of improving quality. Surely my hon. Friend the Member for South Shields is suggesting a parallel measure to the internal clinical audit processes that we already have in health. We cannot rely on external inspections. Inspection has to be seen as a requirement and part of the culture-changing process that we want in health and social care organisations.

Norman Lamb: I completely agree with that. We are doing nothing to stop that. It should absolutely be the culture that there is a sense of constant, continuous internal improvement. I encourage all providers of care to engage in that. The risk is that, if they do not, they will end up with a poor rating and lose customers if they are private or local authority providers. The whole design of the regime is to provide incentives to drive up standards, contrary to the suggestion feared by the hon. Member for South Shields.

The amendments in this group are about the way in which the Care Quality Commission regulates and reviews adult social care. The three amendments tabled by my right hon. Friend the Member for Sutton and Cheam seek to remove the requirement that the CQC seek the approval of the Secretary of State before carrying out a review of local authority commissioning of adult social services. Amendment 126, which the Opposition tabled, has a similar end point in seeking to establish the CQC's power to carry out periodic performance assessments of local authority commissioning of adult social services. Amendments 127 and 128 would require the Care Quality Commission to develop its methodology for performance assessment of adult social services jointly with local authorities.

I will explain our approach in the Bill to CQC reviews of health and adult social care. The thinking behind several amendments is that the quality of commissioning can and does impact on the quality of care. I do not take issue with that. I agree with the points made by Opposition Members and my right hon. Friend the Member for Sutton and Cheam. I have frequently spoken about the importance of improving the quality of commissioning.

10.45 am

That is why, as my right hon. Friend said, we have amended the Bill to ensure that, when local authorities undertake commissioning, they have to consider the well-being of the individuals who will receive care. It is important that commissioning can be reviewed by the CQC, but I want the CQC's main focus to be on the quality of care provided to patients and service users. If we think about it, that must be the most important thing. Let us focus first on the care that individuals receive, and ensure that that is of the highest possible standard.

Meg Munn: I am slightly puzzled by that. Surely the point of commissioning is that it specifies what should be provided, but what if the specification is not correct? I agree that monitoring day-to-day interactions is important but it is not the whole story. Is the Minister not missing a large chunk out?

Norman Lamb: I do not think that I am missing a large chunk. I will try to explain my argument as I develop the theme. While I have the chance, I omitted to say at the start of my contribution that I join hon. Members in congratulating the hon. Member for Sheffield, Heeley on all that she has achieved while an MP. There is life after this place, as she is about to discover. I wish her all the best. It has been a pleasure to work with her on this Committee and elsewhere. She can be very proud of what she has achieved in this place.

The Bill restricts the duty to carry out performance assessments to providers of regulated activities. The Government made changes to that effect in the other place. The amendment I have tabled today is consequential on those changes. It is minor and technical and will remove a single remaining reference to local authorities from what will become new section 46 of the Health and Social Care Act 2008.

For reviews of providers, the CQC will not be under any obligation to seek the approval of Ministers. I repeat the point I made to the shadow Minister: when local authorities provide a service, there is no need to seek the authority of Ministers. Following consultation with key stakeholders, it will develop the method of performance assessment under clause 89 as it sees fit. While local authorities are, of course, key stakeholders that I am sure the CQC will consult in developing its assessment model, I am clear that responsibility for the development of the model has to be with the CQC. As we have sought to reinforce, it is an independent body with responsibility for undertaking inspections.

It will also want to consider other organisations with a keen interest, such as providers themselves and the Association of Directors of Adult Social Services and Care England. It would not be appropriate to require the CQC to develop its performance assessment model jointly with local authorities, as amendments 127 and 128 would do, when the CQC alone is ultimately responsible for that system.

Alongside restricting performance assessments to providers, we are making an important further change to make it clear that the CQC, importantly, can carry out special reviews of commissioning in both health and adult social care. Under the changes we are making, it will have the power to conduct special reviews of commissioning by local authorities, clinical commissioning groups—that is really important—and NHS England, in exceptional circumstances. It will do so with the approval of the Secretary of State when there is evidence that commissioning practice is resulting in poor care for service users. That deals with the point made by the hon. Member for Sheffield, Heeley. When there is a link that poor commissioning leads to poor care is when the inspection of the commissioning process becomes so important.

Paul Burstow: It is helpful that the intention that the CQC can do this has been set out so clearly. Given that some of our earlier discussions have been about the ability to respond quickly, and that there are so many welcome steps in the Bill to grant more independence of action to the CQC, will my hon. Friend explain why it still seems to be necessary for the commission to get approval from a Minister before conducting its inspections?

Norman Lamb: I will come to that in due course.

The point is the pressure on the CQC. We expect a lot from the CQC, as the hon. Member for Leicester West has said. The CQC will be under pressure to achieve its objectives, so it makes a lot of sense to focus its activities on what is most important, which is surely the provision of care. Its central focus should surely be the provision of care, but my point is about when it is clear that the commissioning of care could be leading to poor care by providers.

That will not always be the case. There may be good commissioning in some areas and just very poor provision, in which case the sole focus should be on the provision. For example, my right hon. Friend the Member for Sutton and Cheam made the point that too often commissioning has been carried out on a time basis, rather than being commissioning for quality. I know that he recently visited Wiltshire to see how commissioners can change the approach on commissioning by providing incentives to providers to drive up the quality of care and to focus on outcomes for those being cared for. The whole focus of what we wish to do is to shift commissioning in that direction. However, if local authorities stubbornly refuse to shift to that sort of commissioning and focus on only commissioning on a time basis, which results in short visits and poor employment conditions for workers, with the result of all that being poor care, the focus should absolutely be on the commissioning of care. In those cases, we have the power to require the Care Quality Commission to do the inspection.

Paul Burstow: That is absolutely the point at which the Care Quality Commission should take the action that the Minister has just described. The only question that remains for me is why that cannot be made clear through guidance to the CQC, rather than requiring the CQC to make a submission to the Department before the Minister says yes or no. I do not understand why that process is needed when, in a sense, it is possible through guidance to give CQC the necessary scope to exercise its discretion and conduct such an inquiry.

Norman Lamb: This comes back to the point about the CQC's absolute focus being on driving up standards of care and on the provision of care. If it had the

[Norman Lamb]

authority to pursue commissioning without any other requirement or condition attached, it would be constantly under pressure to widen its scope, which might diffuse the effectiveness of its work.

It is in all our interests, in times of acute financial constraints, that we try to focus the work of the Care Quality Commission on where that is most important, and to look at commissioning only when there is clear evidence of failure. As we have all been saying, one could carry out the tick-box exercise of constantly going back to local authorities that may be performing very well, but what on earth would be the point of that? We would be heating the atmosphere, incurring cost to the local authority and taking money away from care provision. That would be crazy. Let us focus on a more targeted approach in which we undertake the inspection of commissioning when there is clear evidence of a significant problem. I hope that I have reassured the Committee.

Mrs Lewell-Buck: I am after a bit of clarification. If monitoring commissioning is not standard in the first place, how will we know that a special review is needed? Who will spark that and say, "Okay, let's have a special review," if nobody is monitoring in the first place? I am a bit confused.

Norman Lamb: If we think about this, it is actually quite clear. Let us say that the Care Quality Commission is undertaking inspections of domiciliary care providers in South Shields and it becomes apparent that all its domiciliary care is being undertaken through very short 15-minute visits, and that there is insufficient attention to the care of the individuals and no focus on their well-being, contrary to the requirements of the Bill. It thus becomes clear that there is a problem that goes beyond the individual provider and seems systemic in that local area. The CQC would then have clear evidence of a potential failure of commissioning. When those concerns were raised in discussion between the Care Quality Commission and Government—concerns about commissioning failures may emerge in other ways as well—there would be an opportunity to go in and undertake an inspection.

While I am responding to the hon. Lady, I also want to address her points about the work of local authorities to reinforce CQC inspections. I am absolutely sure that in the work that she did in her local authority, her objective was to provide more reassurance about the quality of care but, ultimately, I suspect that we all want a single inspector to be undertaking the job effectively. We must be concerned—providers often raise this concern—about repeat visits by the Care Quality Commission and local authorities, with a duplication of inspection by two different bodies. The more close collaboration we can have between local authorities and the Care Quality Commission to ensure that there is a single inspection process in which everyone has confidence, the better. Ultimately, we want to use no more resource on inspection than is necessary so that available resources are used to provide great care.

Meg Munn: I understand that the intention is to reduce the need for the inspection of commissioning when everything seems okay, but why it is necessary for the Care Quality Commission to speak to the Government about that and to get the approval of the Secretary of State? Secondly—I have no doubt that my hon. Friend the Member for South Shields will be able to explain this more clearly—I disagree with the idea about a single point for inspection. Inspection takes place after the fact. Surely building on work done locally is more likely to achieve good-quality care than just waiting for somebody to come along and check things.

Norman Lamb: I fully understand that if a local authority is commissioning and paying for care in local care homes or from domiciliary care providers, it will want to assure itself that it is spending money appropriately and that the individuals are receiving good-quality care. I am just pleading for much closer co-ordination and collaboration between local authorities and the CQC so that they do not duplicate their work. It really frustrates providers when they are subject to endless inspections that cover the same ground as a previous group of inspectors. We must simplify the process so that we reduce the unnecessary regulatory burden on providers while being assured that a single inspector is doing an effective job.

11 am

Mrs Lewell-Buck: For clarification, the inspection model that I was talking about would sit on top of CQC inspection. I have spoken to numerous providers, social workers and families, and they have all said that that model drives up standards. It is aspirational and it actually improves care. There is a reason why other local authorities have copied the model: it works, it saves lives and it makes everyone feel more comfortable about the care offered in their locality.

Norman Lamb: I would be interested in having a further chat with the hon. Lady about the model in due course. I am concerned about duplication of activity. In some areas, that sort of approach has happened because there has not been confidence in rather generic CQC inspections. The model introduced with the CQC back in 2008, which I must say I think was a mistake, was based on generalist teams of inspectors. One week they might have been inspecting dental practices, the next an acute hospital or a mental health facility. It seems much more sensible to have specialist inspectors, particularly including clinicians, where appropriate, and users of services. In that way we can achieve much more robust, thorough inspections. If those are combined with an objective assessment through the rating of a provider, we will start to get a much better understanding of the quality of care and create an incentive to drive up standards.

Mrs Lewell-Buck: I want some clarification, because the care homes that I have spoken to tell me that the CQC comes in and just does a straightforward desktop exercise, where, basically, they look at a few files, make an assessment and disappear again. The model I am talking about is three days' worth of in-depth, thorough assessment of absolutely everything that goes on in a particular home. I am curious as to whether the Minister is going to try to strengthen how the CQC carries out its inspections. If not, it is vital that the model I am referring to is in place as that extra safeguard.

Norman Lamb: That is absolutely the point. I am now beginning to understand why the hon. Lady talks about the need for something in addition to what has traditionally been the case. Her description of the traditional CQC inspection gives no one any confidence. She described a paper, tick-box exercise, which is hopeless in terms of reassuring anyone about the quality of care. That is the change we are seeking to achieve.

The new leadership of the CQC is totally committed to a different approach, where the inspection, whether of a care home, an acute hospital or a mental health facility, is much more robust and actually looks at the quality of the service provided. Inspectors will talk to members of staff, for goodness' sake—bizarrely, that has not been a significant feature of the regime until now. They will talk to service users and perhaps to relatives who visit the care home. In that way, we can get a thorough, robust inspection and an outcome that will feed into providers' ratings.

I think the hon. Lady might agree that if we can achieve that robust process, that will give reassurance and avoid the need for any duplication of effort between the local authority and the CQC. She is absolutely right that the local authority should reassure itself of the quality of care if it believes that the CQC process is a tick-box exercise. We want to eradicate such exercises so that people have confidence in the CQC and the work that it does.

Meg Munn *rose—*

Norman Lamb: I am stuck on paragraph 9 but determined to get beyond it. I will give way to the hon. Lady, but I will not then give way again.

Meg Munn: With respect, the Minister forgot to answer my first question: why is there a requirement for the CQC to come back to the Government if it wants to inspect commissioning?

Norman Lamb: I apologise for that. I responded to the same point when it was made by my right hon. Friend the Member for Sutton and Cheam, but I had intended to repeat that in response to the hon. Lady. If organisations are given powers to do things, they will feel under enormous pressure to use them and, thereby, diffuse their efforts and reduce their effectiveness in the areas in which we want them to focus their attention. The additional condition of the Secretary of State sanctioning the inspection of commissioning ensures that the Care Quality Commission will focus on its core task: driving up standards of the provision of care, which is what we are all ultimately concerned about. I repeat that it is in the Government's interest—whoever happens to be the democratically elected Government of the land—to ensure that, where there is that clear link between the quality of commissioning and poor care, the inspection of commissioning can take place.

Now I will get on to paragraph 9. Concern has been expressed about the change we are making, with service providers arguing that that will leave them answerable for failings in care that, in reality, have their roots in commissioning, and scepticism has been expressed about whether Ministers will ever approve a special review of commissioning. I want to be clear with the Committee on that point.

If my intention was for the CQC never to carry out a review of commissioning, I could have proposed to remove its power to do so from the statute book. I accept that there is a link between commissioning and quality and the CQC should be able to look into that, but only where there is clear evidence of a problem. Its main focus must be on providers. As far as I am concerned, where that link is established on a prima facie basis, these powers should be used because we must be able to challenge poor commissioning that leads to poor care. I hope that that provides reassurance to my right hon. Friend.

I have been asked what areas such reviews will consider and whether the CQC will be able to review 15-minute commissioning, as referred to by my right hon. Friend, and look at commissioning where evidence exists of poor employment conditions of carers resulting from that. My reply is the same in all cases: if there is strong evidence of a link between commissioning and poor care, the CQC will have the power to look into that.

Anne Marie Morris: Will the Minister also consider examining pricing? One of the challenges in commissioning is the basis on which the decision is made and it seems to me that that should be based on quality and not simply on cost.

Norman Lamb: If the local authority was unrealistically pricing care in its commissioning and there was a clear link between that and poor care, as in the other examples, that could provide a basis on which the CQC could inspect that commissioning function. It is about focusing on clear evidence and setting the bar quite high so that it does not need to be constantly poring over local authorities' work and taking resource away from actual provision of care. It is important to focus the work of regulators on where there is evidence of a serious problem. If these powers are used where there is such evidence, that will send out a signal to local authorities that if they engage in poor quality commissioning, there will be potential consequences. That is important in driving up standards.

Paul Burstow: That would indeed send that powerful message. Will the Minister indicate whether he will give some thought to my suggestion of a themed inspection of sector-led improvement to address the concern that emerged in the Committee about whether we are really getting the results that we want?

Norman Lamb: I will give thought to that—not just casual, complacent thought, but serious thought. My right hon. Friend makes a reasonable point and I share his concern that the danger with sector-led improvement is that those bodies who are up for change and improvement take part and those who are dysfunctional and failing do not engage.

Why then could this power only be exercised with the agreement of the Secretary of State or, in the case of reviews of local authority commissioning, the Secretaries of State both for Health and for Communities and Local Government? I return to my starting point: I want the CQC's main focus to be the regulation of providers of health and adult social care. The oversight of commissioning is not the core purpose of the CQC.

[Norman Lamb]

Any review, investigation or study by the CQC of the commissioning of services will impact upon its capacity to oversee service provision. It is a finite resource, and we all understand that. For it to perform this function should be an unusual rather than a routine part of its work. It is therefore right that any review of or investigation into commissioning is subject to ministerial agreement.

I hope that I have reassured my right hon. Friend and, indeed, Opposition Members that there absolutely is an intention to look at the quality of commissioning where this is justified by the evidence. However, this should not be done as a matter of routine because that would take resource away from the provision of care, which is what we are all after.

Paul Burstow: I agree with the Minister that it should be intelligence-led. It should be based on the evidence, not done as a matter of routine or by rote. However, that does not suggest to me that the Minister is therefore required to stand as the bulwark against all sorts of pressures on the CQC to conduct these inspections willy-nilly. That is why, while I entirely accept and very much welcome his reassurances about the intention to use this power, it seems to me that there would have been a way to do this through guidance. Criteria could have been set out to enable the CQC to say that it cannot do an inspection on this basis, because the evidence threshold has not been reached and it is not worth doing.

I say that to the Minister, but I appreciate what he has said about sector-led improvement and that he will seriously and meaningfully consider it. It would be good for him to do that, and then to reach a conclusion sooner rather than later. My reason for saying this is that if he states that he will commission the CQC to do such work, it would have the benefit of putting local authorities on notice that sector-led improvement is not the only game in town and will be put to the test. That would help raise the game for many of those authorities that are not really participating or that do not take it seriously. It would be a useful spur to drive sector-led improvement in a positive direction.

With that, and with the very welcome assurances the Minister has given in this debate, notwithstanding I am still concerned about why a Minister needs to sign off such an action, I am happy to withdraw the amendments.

Mr Reed: Briefly, I offer one tiny clarification. I appreciate that the Minister has been exceptionally generous. He is entirely right about the duplication of effort, which of course we do not want to see, and he is entirely right about the finite resources we have to spend. I genuinely do not want to test his patience any further, but I would like to raise the issue of inspection triggers. Suppose the CQC was to inspect a local hospital trust and see something, whether bed blocking or some other quality of care failure, which was obviously a canary in the coal mine with regard to the local authority's provision in this regard. Would the CQC have the power to immediately investigate the relevant local authority, without recourse to ministerial approval?

Norman Lamb: Just to be clear, where the local authority is a provider of a service registered with the Care Quality Commission, there is no obligation on the CQC to seek the approval of any Minister. Where the local authority is the commissioner of care, then there is a requirement to seek the authority of the Secretary of State. I stress again that there is the potential power to look at commissioning by clinical commissioning groups as well as the local authority, so there is a sort of equilibrium in the system by way of this clause.

Mr Reed: I will not press the amendment to a vote.

Paul Burstow: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 88 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. —(*John Penrose*.)

11.15 am

Adjourned till this day at Two o'clock.