Lord Patel

223A: Clause 180, page 176, line 16, at end insert—

"( ) After Section 158 (Duty to consult Board in relation to regulations about patient information) insert the following new Section—

"Representation of Patients' Interests

Healthwatch England

(1) There shall be a body corporate known as Healthwatch England.

(2) The primary duty of Healthwatch England shall be to represent the interests of patients and users of national health services and social care services (hereafter known as "patients and users") in relation to providers, regulators and the Secretary of State.

(3) Healthwatch England shall be independent of any provider of national health or social care services or of any regulator of health or social care or of any other body established by this Act or otherwise.

(4) Healthwatch England shall have the following functions—

(a) to establish a local healthwatch organisation for each local authority area;

(b) to provide each local healthwatch organisation with such resources as may be agreed by Healthwatch England;

(c) to provide local healthwatch organisations with advice on, and assistance in relation to, their functions and on such other matters that Healthwatch England may determine; and

(d) to provide relevant persons with information and advice on—

(i) the views of people who use health and social care services and of other members of the public on their needs for, and experiences of, health and social care services; and

(ii) the views of local healthwatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved.

(5) Relevant persons referred to in subsection (4)(d) are—

(a) the Secretary of State;

(b) the National Health Service Commissioning Board;

(c) the Care Quality Commission;

(d) Monitor; and

(e) English local authorities.

(6) A person provided with advice under subsection (4)(d) must inform Healthwatch England in writing of his or her response or proposed response to the advice.

(7) Healthwatch England shall in addition have powers of investigation as prescribed in subsections (8) and (9) and powers to require disclosure of information as prescribed in subsection (6).

(8) Healthwatch England may investigate—

(a) a complaint made by or on behalf of a patient or user or a local healthwatch organisation which appears to the Board to raise one or more issues of general relevance; or

(b) any matter which appears to the Board of Healthwatch UK to be or be related to a problem which affects or may affect patients or users generally or patients or users of a particular description.

(9) For the purposes of subsection (8) a complaint raises an issue of general relevance if it raises—

(a) a novel issue which affects or may affect patients or users in general or patients or users of a particular description, or

(b) any other issue which has or may have an important effect on patients or users generally or patients or users of a particular description.

(10) Healthwatch England may by notice require a person within subsection (11) to supply it with such information as is specified or described in the notice within a reasonable period as is so specified and the information so specified or described must be information that Healthwatch England requires for the purpose of exercising its function.

(11) The persons referred to in subsection (6) are—

(a) any provider of health or social care services licensed by the Care Quality Commission and Monitor under the provisions of this Act;

(b) the National Health Service Commissioning Board;

(c) Monitor;

(d) Care Quality Commission; and

(e) any other person specified or of a description specified by the Secretary of State.

(12) If a person within subsection (11) fails to comply with a notice under subsection (10) the person must, if so required, give notice to Healthwatch England of the reason for the failure and if that reason for failure is not acceptable to the Board of Healthwatch England then the Board of Healthwatch England may take steps to publish the notice and the reasons for failure provided or to seek enforcement of the said notice through the courts.

(13) Healthwatch England must publish details of arrangements it makes under this section, including details of payments of remuneration or other amounts.

(14) In performing functions under this section, Healthwatch England must have regard to such aspects of Government policy as the Secretary of State may direct.

(15) As soon as possible after the end of each financial year, Healthwatch England must publish a report on the way in which it has exercised its functions during the year.

(16) Healthwatch England must—

(a) lay before Parliament a copy of each report made under subsection (15); and

(b) send a copy of each such report to the Secretary of State.

(17) Healthwatch England may publish other reports at such times, and on such matters relating to health or social care, as it deems appropriate.

(18) Before publishing a report under subsection (15) or (17), Healthwatch England must, so far as practicable, exclude any matter which relates to the private affairs of an individual, the publication of which, in its opinion, would or might seriously and prejudicially affect that individual's interests.

(19) In this section "financial year" means—

(a) the period beginning with the date on which Healthwatch England is appointed and ending with the following 31 March, and

(b) each successive period of 12 months ending with 31 March."."

Lord Patel:

My Lords, Amendment 223A and those that follow, which relate to local healthwatch, are the key amendments that address public and patient involvement in the Bill. The Bill says a lot about how the patient will be centre stage in the whole reorganisation. Therefore, it is important that the patient's voice be heard. How will we do that?

I say at the outset that my amendment is about the independence of HealthWatch England in statue and its ability to get the information about health services that it will need to do its job. Public involvement in health and social care in England has been in a turbulent state since 2003. Despite the genuine aspiration of the Government to establish an effective system of public involvement, they have failed. This is now the fourth, or even the fifth, attempt to do so.

In 2003, more than 500 patient forums were set up around the country, many with a tiny membership. They had an independent national body, which was distant and isolated from local patient forums. It failed because it was neither useful to nor respected by local forums. The abolition of patient forums led to Local Involvement Networks being established with no statutory national body. The name LINks made them invisible to the public. They were often isolated and struggled against the odds to develop

successful systems to monitor services and influence commissioning. Nevertheless, after two or three years, many LINks have done well; they have established a good local reputation and had an important impact on the effectiveness of local services. However, they need a national body to support them, enable them to develop successfully and give a hand to those that are failing.

Recognising the problems and weaknesses of some LINks, the Government decided to abolish them and replace them with HealthWatch. The plan—to have a national body called HealthWatch England, working closely in a supportive relationship with local healthwatch—is very good. The intention is for HealthWatch England to be up and running by 1 October 2012 and local healthwatch by 1 April 2013. Ministers had a vision of a relationship between the local and the national that went in the right direction but needed some tuning to make it work for the benefit of the public. However, the plans that the Government now have for both HealthWatch England and local healthwatch may risk that vision being realised.

To succeed, HealthWatch needs strong input from people with practical experience of building a successful national HealthWatch England that works in tandem with local healthwatch. A national governance framework is required from the centre to enable local people to get on with the job. Supportive governance from the centre reduces local friction and speeds the process of local development. HealthWatch England should provide a national vehicle to drive standards in health and social care and identify areas of poor practice. It has a very special mission, which is quite different from that of the regulator, CQC, of which the Government want HealthWatch England to be a committee.

HealthWatch England should be the voice of the people—the voice to which the Secretary of State must listen in making the CQC, Monitor and the Commissioning Board have a strong relationship. HealthWatch England is the voice of the abused patient, the forgotten person with dementia on the second floor of a nursing home, of the child with a learning disability who is getting poor care on a children's ward and of the people waiting excessive periods for emergency care in an A&E department. When local healthwatch or a member of the public raises their voice because of a persistent local problem—as occurred in Mid-Staffordshire—HealthWatch England must hear it and respond immediately. To do this, independence is critical.

Embedding HealthWatch England in the CQC is a fundamental error. To call it a committee is a fundamental error. It diminishes the power and influence of HealthWatch England if it becomes a committee of the CQC. The only people who think that a committee is important are the people who sit on it. Having sat on many of them, I might agree. Most people think a committee is a talking shop. HealthWatch England must not be thought of across the country as a talking shop.

The CQC has a huge and important job to do and needs to be supported. I do not deny that. However, the way in which it deals with that job is seen to be highly bureaucratic. It has the wrong culture for a public body such as HealthWatch England. Members of the public will not wish to go through a CQC call centre or website to raise urgent issues. They will want to speak to an expert in HealthWatch England who will understand the problem and can act immediately. Combining the people-facing body of HealthWatch England with the regulator by making it a committee of the CQC, which is focused on data and regulation, will quickly suffocate it. That cannot be what the Government want to do.

It has been argued that locating HealthWatch England within the CQC puts it at the centre of regulation, where it can have real power and influence. However, it cannot have power and influence if it is a committee of the regulator. To have power and influence, it needs independence and the ability to challenge the regulator. HealthWatch England needs to be trusted by the public and to be seen as a big

hitter. It must be seen to be able to hold the CQC, Monitor and the NHS Commissioning Board to account, and to have influence with every local authority in England. It must be seen to be independent, and not just called independent.

Being independent and being seen to be independent requires HealthWatch England to be run by a board that has public trust and confidence, meets in public and speaks to the public, not a board—as CQC is—that does not even allow questions to be put by the public. It would be absurd for England's leading public involvement body to be the statutory committee of a board that does not even recognise the need to be open and accountable to the public. HealthWatch England must have its own board, which must meet in publicly accessible places to discuss issues of national importance in healthcare. It must be seen as a body that people will want to connect to by attending its meetings, raising issues with it, watching it live on the internet and engaging with it. It must be what might be called a living organisation, not an obscure committee of some other big national regulator.

The CQC seems very anxious about having members of the HealthWatch England committee elected directly from local healthwatch. Why is it so worried about a little democracy? The recent consultation on the regulation of HealthWatch England was silent on independence and elusive on elections. It considered the possibility of election to HealthWatch England, but not directly to the HealthWatch England committee as it sees it. It would have to be through some intermediate mechanism just in case a rogue representative was elected to the committee who might challenge the CQC, I suppose. HealthWatch England cannot be seen to be a part of the CQC and to operate in its shadow, fearing direct public involvement. As a regulator, the CQC may have to keep a distance. To ensure objectivity as the people's voice, HealthWatch England must invite the people in and be disappointed if they do not turn up. If they do not show up, HealthWatch England will have failed in its job as a public and patient representative. Direct election from local healthwatch organisations to HealthWatch England would ensure that HealthWatch is a national and local organisation that people can trust.

2 pm

Strong relationships with the CQC, Monitor and the Commissioning Board are critical. Local relationships sharing critical information will be required between the CQC inspectors and local healthwatch organisations. HealthWatch England must have the power to ask for information and get it. The sharing of data nationally will be essential. This process could easily be established through an agency agreement requiring reciprocity on key issues of patient safety, quality and access between HealthWatch England and the CQC. The relationship with the Commissioning Board in relation to its patient safety arm will be just as important to HealthWatch England as the CQC arm. The anxieties that the Government may have about HealthWatch England failing may have made them overreact in making it a committee of the CQC, but I think that is an error. I hope that the noble Baroness will address those issues when she replies.

Are the Government minded to accept that HealthWatch England could have its independence without being a committee, and be hosted by the CQC so that the latter can provide all the backroom facilities to enable HealthWatch England to develop a strong relationship with it? HealthWatch England could have representation on the CQC but its staff should not be employed by the CQC. HealthWatch England should have an independent board and an independent chair and be the voice of the people. Bodies outside such as NALM and LINks are anxious that HealthWatch England might become an obscure committee. I hope that the noble Baroness will address those issues. I beg to move.

Lord Harris of Haringey:

My Lords, I think this is the part of the Bill which I assume the Minister had hoped would give him a quiet time. Indeed, he has passed on the responsibility for answering this amendment to his noble friend Lady Northover. Originally, one had to respect the Government's intention with regard to HealthWatch because I am sure the intention was to create effective patient representation at national and local level. That intention has been challenged in the discussions that we have subsequently had and in some of the changes that have occurred over the past few months. However, it is worth going back for a moment to first principles. What constitutes effective patient representation? The first significant element of that has to be independence. The organisation representing patients' interests has to be independent of the providers of health services, those who commission them and those who regulate them because the act of representation can potentially challenge any or all three of those interests.

Secondly, effective representation at national level must be representative. There must be real representativeness within that structure. It must be derived from local groups and local individuals and have that authority which is derived from being a representative structure. With the best will in the world, you cannot be an organisation which can speak with proper authority on behalf of patients or, indeed, any consumers if you are simply appointed from on high by a Secretary of State. In my time, I have worked for organisations that have been structured like that and I have to say that although they can do good work, they cannot be properly representative. They cannot properly have the authority that comes from being derived from the grass roots. The third element which is critical is that the work and the comments that these bodies produce have to be derived from sound local information, which necessitates being able to pick up information from local networks around the country. That has to be safeguarded in whatever proposals are put forward.

The Government originally promised us that HealthWatch England would be the independent patients' champion. However, as the noble Lord, Lord Patel, has just pointed out, being a subcommittee of the Care Quality Commission does not demonstrate independence. It demonstrates a subsidiary role in relation to the Care Quality Commission. I am sure that the people currently at the Care Quality Commission are motivated to try to create an arm's-length structure. We do not know, of course, whether that desire for independence would survive the first occasion when HealthWatch England challenged the decisions made by the Care Quality Commission, or how often it would survive after repeated such challenges. However, independence is also about the perception and the appearance of being independent. How can you appear to be independent if you are a subcommittee of one of the organisations that you may have to criticise from time to time?

This amendment seeks to do three key things. It would set up HealthWatch England as an independent statutory body and write that independence into statute, set out a clear relationship with local healthwatch organisations and safeguard their funding mechanism. I recall some very wise words said to your Lordships' House in July 2007 when we were debating the creation of the Commission for Patient and Public Involvement in Health. It was stated that,

"one signal advantage of the commission is that the money that it distributes to forum support organisations cannot be used for purposes other than those for which forums were established. Under the arrangements in the Bill, however, there is no guarantee at all that money intended to support the activities listed … will actually reach the front line. It would be possible for a local authority to say that it was delivering the activities in the Bill when, in reality, those activities were so minimal that they were hardly worth the name of patient and public involvement. What steps could be taken, in those

circumstances, to ensure that such involvement in health and social care is delivered properly?".—[Official Report, 23/7/07; col. 615.]

The person speaking said that the answer was not delivered by the Bill brought forward at that time by the Labour Government. Who was the person who delivered those words? It was, of course, the noble Earl, Lord Howe—the current Minister. He made it quite clear that the arrangements which he is now seeking to replicate were not adequate and would not, and could not, work. Yet the proposals which were going to establish the independent patients' champion are weakened precisely because he has not accepted the lessons of his own words.

The noble Earl, Lord Howe, went on to say that he was concerned that, as:

"LINks are going to assume different forms and guises in different localities, it is axiomatic that the level of activity that they undertake is going to vary".—[Official Report, 23/7/07; col. 615.]

He asked how the amount of money in any given area was to be assessed. Therefore, I ask the noble Baroness—who will respond on behalf of the noble Earl, who gave us that wise advice in 2007—what will be the mechanism for determining how much money is allocated to each local authority for healthwatch in its area? Will this be a global sum that will go from the Department of Health to the Department for Communities and Local Government, and then be allocated to local authorities by the mysterious process by which the block grant from the DCLG is decided for each local authority area? Or will there be a separate formula that will go with that money and decide how much money is allocated to local healthwatch around the country? If it is the latter, will that information be published? Will it be possible for residents in a local area to know how much money has been allocated so that they can see whether it is being used? I suspect that unless we have the answers to those questions we will know that the reality is that this money will disappear in the wash and not be effective. The point about the amendment is that it provides a solution to that problem because the same money would be channelled through a body that would be dedicated to the provision of local healthwatch organisations and want to ensure that the money was spent properly and appropriately.

The Government's arguments—we have had several discussions about this with Ministers, and I am grateful to the noble Earl and the noble Baroness for providing those opportunities—seem to be broken down into three areas. First, they argue that there is a natural synergy with the work of the Care Quality Commission. However, I have already pointed out that the CQC is one of those bodies that HealthWatch England may have to criticise. There is also a synergy with the work of the NHS Commissioning Board, Monitor, Public Health England and all sorts of other parts of the new NHS. Why is there specifically a synergy with the CQC?

The Government's second argument was that there would be cost efficiencies and that this would be the most efficient way of doing this because there would be savings due to the collocation. However, as the noble Lord, Lord Patel, pointed out, you can achieve that in many ways. You can simply say that one of the things that HealthWatch England, as an independent statutory body, could be required to do through guidance, would be to look at how its back-office operations could be provided from a variety of organisations of appropriate stature and size, where the issue of conflict would not necessarily arise. That provision could then be made by way of a clear legal agreement. However, that is not being done, and I am not quite sure why the Government are saying that there are efficiencies and cost savings that could be made only by the precise structure that they propose. In terms of providing the funding to local healthwatch, our proposal has to be a more efficient provision that will deliver the resources without

leakage and without local authorities deciding that perhaps there is a greater local priority than local healthwatch.

The noble Baroness, Lady Northover, spoke vehemently about the way in which the former Commission for Public and Patient Involvement in Health had operated, and how it had a wasteful and top-heavy way of distributing resources to local patients and for public involvement. That is not the only way to distribute resources. The only reason that the former commission distributed resources in that wasteful and inefficient way is because the Department of Health at that time—I regret, led by a Labour Minister—insisted that it was done in that rather ridiculous and cumbersome way. If Ministers want distribution done efficiently and simply, perhaps that can happen. If you appoint the right people to the initial board of HealthWatch England, I am sure that they would want to ensure that that is the case. It does not have to be done in the way I described.

The third argument that I have heard Ministers make for locating this body within the CQC is that it will provide all sorts of informal support and guidance—that there will be a library, information resources and so on. However, the Government have told us how important the duty of collaboration is within the new NHS and how significant it will be. Why do you need to collocate and have HealthWatch England as a subordinate structure within the CQC when there is a duty to collaborate? Indeed, why cannot HealthWatch England collaborate with other national bodies as part of the NHS?

Within this group there are other amendments, including Amendment 224 and 225, which propose that the majority of members of HealthWatch England will not be from the CQC and will be appointed by local healthwatch. I have two concerns about those amendments. Why cannot all the members be derived from local healthwatch organisations? The bigger question comes in a later group of amendments, which is: if you have destroyed the statutory status of local healthwatch organisations, how can contractors, which will be delivering local healthwatch services at a local level, deliver representatives to a national structure? Will we thereby have representatives of different local social enterprises appointing people to sit on a national body? That is a strange representative structure.

Then there is Amendment 226ZG, which is the Government's answer as to how they make sure that local healthwatch organisations are satisfactory. This gives HealthWatch England—this sub-committee of the Care Quality Commission—the power to write a letter. It is the power to write a letter to a local authority and say, "In our opinion, the local healthwatch organisations that you have organised in your area are insufficient". My goodness, as a former local authority leader, I know that I would be quaking to receive a letter from a sub-committee of a national organisation that did not really regulate anything that I was particularly bothered about, telling me that I was not doing something absolutely right. There would be no enforcement powers and no means of intervention, but the power to write a letter. Brilliant. Excellent. It is just what we are looking for. It offers hardly any solution, although I appreciate the concession that the noble Baroness and the noble Earl have made in that amendment.

I conclude by saying that this is not a party-political issue. The previous Government got this wrong and, sadly, the present Government look as if they are about to get it wrong. This was an opportunity to get it right. Patients need effective representation, particularly in the context of the Bill. Even if you believe that the Bill will deliver to us a better health service—and I am obviously not one of those—patients need to be given confidence that their interests will be properly represented. At the moment, the arrangements proposed by the Government do not do that. That is why an independent HealthWatch England is so important.

Baroness Masham of Ilton:

My Lords, with so many changes over the years to volunteers supporting patients, it is important that HealthWatch England and local healthwatches should be effective. First, there were community health councils, most of which did a good job—some did not. Then there were health forums, which lasted only two years. Then there were LINks, which have not been very well supported. The way that these volunteers, who were supposed to be a voice for patients and people using social care, have been treated has not been good. Unless healthwatches have a strong voice and enough support to operate, they will not be able to do a worthwhile job. They need to be independent so that when they see something that needs to be improved they can speak out.

In the Mid Staffordshire Hospital, where the culture was wrong and patients suffered, no one spoke out when they should have done—except the relatives. I hope that lessons will be learnt and strong safeguards put in place, including a strong healthwatch. I know that the noble Earl understands the need for a body supporting patients that is fit for purpose. If the House thinks that HealthWatch England and local healthwatches are not fit for purpose, as suggested in the Bill, and if the amendments are not accepted, perhaps with the help of the Minister there is still time before Third Reading to get it right.

I ask him whether children's services are to be included in healthwatches. If not, they should be. Just think of what happened to Baby P. We must not forget. It will be very disappointing if we do not get it right in your Lordships' House.

Baroness Cumberlege:

My Lords, I have several amendments in this group and the next one. There are synergies between the two groups, so I shall speak briefly introducing both groups and go on to those in this group.

I have tried hard throughout our debates to ensure that we have a more robust accountability framework. As I see it, the framework is in three parts. First, there is the local authority. Secondly, there is HealthWatch England. Thirdly, there is the local community. I will not go into the independence of HealthWatch England, because I debated it very fully in Committee, but I understand the passion that has been expressed on that issue. For me, those three elements balance each other, and it is important that they do, because that will improve transparency.

To give an example, if HealthWatch England makes recommendations to local authorities on how they commission local healthwatch, local healthwatch and the community can hold the local authority to account for how it commissions. That gives it a yardstick by a third party, HealthWatch England, against which to measure the local authority commissioning arrangements. The policy document produced by the Government on Friday, Local Healthwatch—The Policy Explained, states that the Government are considering how the constitution and governance of local healthwatch needs to ensure that it operates for the benefit of and is accountable principally to its local community.

The third element is local people. They are critical to the accountability framework. As the noble Baroness, Lady Masham, said, in many eyes, they are the most important.

The government amendments, including those laid on Friday, go some way to addressing that, but they also introduce fresh concerns, which I shall refer to later. The loss of statutory structure is a great threat to

independence. The value for money and rationale still have to be adequately explained, but I am sure that my noble friends on the Front Bench will do that shortly.

My noble friend Lady Jolly and I tabled Amendment 224, which improves accountability nationally by linking the perspectives of HealthWatch England more closely to the grassroots by electing the members of local healthwatch to the HealthWatch England statutory committee. The noble Lord, Lord Harris, gave that a warmish welcome, although I say to him that that is not a sub-committee, it is a committee. It is not subservient to a committee, it is a committee.

The Government have sought broader opinion with their public consultation on that and other topics which closed on Friday. That elected membership would serve two functions: first, as a counterweight to the influence of the Care Quality Commission, making HealthWatch England more independent; and, secondly, as an agent for the accountability of HealthWatch England, keeping it in touch with the patient and user reality. If local healthwatch does not think that HealthWatch England is really speaking out for people, it can say so through its elected representatives. They would be elected against a skill specification to ensure that they were the right people to fulfil that important role. Without that, HealthWatch England is a free-floating organisation with no local connection, a mere national harvester of local data. I hope that the Minister can reassure me again that that accountability gap will be dealt with.

Government Amendment 226 is very much welcomed. I strongly support it, because it responds to my amendment in Committee. It provides for the majority of the members of HealthWatch England to be made up of non-CQC members, making it independent of the CQC, which therefore cannot dominate HealthWatch England. My Amendment 226A stitches the accountability framework together transparently, by providing for local healthwatch to have regard to the standards set by HealthWatch England. I hope that my noble friend can give me some assurances as to how that last element can be covered.

The introduction of the HealthWatch trademark under government Amendment 235C is a very interesting device and may well help. Amendment 228 was also tabled by my noble friend Lady Jolly and me. It enhances independence and transparency nationally by providing for the Secretary of State to issue conflicts guidance to which both the CQC and HealthWatch England must have regard. I hope that the Minister finds that sensible. Amendment 229 is another government amendment which I support. It includes a risk management strategy, so that what may have gone wrong in one place may stimulate vigilance in another. I strongly support that.

I am sure that my noble friend will wish to speak to her amendments, but I have introduced mine and hope that some of them find some favour with those on the Front Bench.

Lord Whitty:

My Lords, I want to add a couple of brief points to the already powerful case made by the noble Lord, Lord Patel, and my noble friend Lord Harris. I do so from some experience of the consumer interest in other markets. First, I resort to what the clause says is the purpose of the HealthWatch England committee. It states that it is,

“to provide the commission or other persons with advice, information or other assistance”—

not to challenge, not to represent the user interest, not to deal with issues of general complaint but to provide assistance to the body of which it is a committee. That is not a sufficiently powerful role to fulfil the requirements for independence.

This has been tried in other sectors. Until 2006, when I brought legislation through this House, there was a panel to represent consumers within Ofwat. Since that has been removed, and in contrast to the first 20 years of the privatised water industry, the Consumer Council for Water has represented the consumer interest effectively in terms of price review and influence on the individual water companies, region by region. That has been an improvement.

There are two other examples where regulations have required panels within existing regulators. One is in communications, where Ofcom had a consumer panel. Frankly, that has withered on the vine because Ofcom has not supported it or given it adequate resources. The other is in financial services, where the Financial Services Consumer Panel has done some sterling work, but no one could claim that the interests of consumers has been fully protected through the past five years of financial service provision. Noble Lords may remember that when our colleague, the noble Lord, Lord Lipsey, was briefly chair of that panel and attempted to extend the interests of consumers more independently from the regulator, he found it necessary to resign. That is not a good model for independence either. Although that panel does good work, it has to follow the rhythm and priorities of the regulator, not the priorities, concerns and interests of consumers. If you are part of an organisation, a committee or sub-committee of an organisation, that inevitably follows.

The other point that I wish to raise concerns powers, my views on which are set out in subsections (7) to (12) of the proposed new clause. Unless the consumer organisation has separate powers from those of the regulator to require information and advice, then, again, it cannot be truly independent. The powers are very similar to those of the other independent, statutorily based consumer organisations, and it will require information from the regulators, the commissioners and the providers within the complex new structure of the health service that we are setting up here.

On both those counts, there is no experience elsewhere of consumers' interests having been effectively represented by a committee, a panel or a sub-committee within one of the three overlapping regulators, all of which impact on the users of the health service under the Bill.

Unless the Government rethink this, they will be doing a great disservice to all the hundreds and thousands of people out there who depend on care services and on the National Health Service. The reality is that all the Minister needs to do is to tell us today that he is going to reject the idea of a committee and genuinely come forward with a proposition that gives independence to consumer representation within the new structure. If we get anything short of that, I think we will have let down the users of the National Health Service.

2.30 pm

Baroness Jolly:

My Lords, I have a couple of amendments in my own name in this group, and I shall also speak to amendments in the names of my noble friends Lady Tyler and Lady Cumberlege.

We welcome the decision to set up a patient and public involvement organisation and network across England based on local authority geography and with HealthWatch England at the centre. It offers the possibility of real engagement for all stakeholders and the consequent improvement of health and social care services for all. However, there are still some areas for concern in relation to HealthWatch England, whose role is to engage with all the key national players—the Secretary of State, the NHS board, Monitor, the CQC and the local authorities to which I referred a moment ago. It is charged with providing the views of those in receipt of services, their carers and other members of the public, and also with offering advice to the key stakeholders to whom I have just referred. It will thereby be influencing the Secretary of State mandate, commissioning practices, the process of registration of providers and the authorisation of clinical commissioning groups.

However, there is a deficit in the Bill. There is no representation on the HealthWatch England board of a local voice. Reports may be sent by local healthwatch organisations and they may be read, but there is no one on the board of HealthWatch England who can tell it as it is at a local level. The board, as with all other boards, is charged with making decisions involving running the organisation but, without a local perspective, it runs the risk of being metrocentric, south-east based and out of touch. Therefore, I support Amendment 224 in the name of my noble friend Lady Cumberlege and, as a good Liberal Democrat, I of course welcome elections run by STV.

The relationship between HealthWatch England and local healthwatch organisations has to be pivotal to the success of this proposal, and one certain way to cement that is with the presence on the HealthWatch England board of members of local healthwatch organisations, as we have just discussed. However, another way would be to use Amendments 229A and 234ZA in the name of my noble friend Lady Tyler. These allow for local healthwatch organisations to have a power to recommend to the board of HealthWatch England the reports that they think, from their local information-gathering, HealthWatch England should carry out, and HealthWatch England is bound to have regard to these recommendations. This should help to avoid situations such as Winterbourne and Mid Staffs. An effective local healthwatch organisation would have confidence that its advice would be considered and acted upon by HealthWatch England, precipitating early intervention and service improvement. It would also allow HealthWatch England the opportunity to spot national patterns, determine their significance and take appropriate action.

I have an amendment in my own name which concerns specialised services commissioned by the board—in particular, those for rare and complex conditions. Here, I need to declare an interest as chair of the Specialised Healthcare Alliance. I should be very grateful if my noble friend could clarify how it is envisaged that information can be collected about these services, how patients and carers can have confidence in a local healthwatch organisation dealing with issues with which they might only rarely get any concerns, and how HealthWatch England can put these scarce data together in a useful and timely manner for stakeholders. That will need careful management and crystal-clear guidance to ensure that the information gathered and the advice based on that information find their way to the board. Many people with such conditions are keen to hear the Minister's response and I would welcome total clarity from her in that regard.

Baroness Pitkeathley:

My Lords, I wish to speak in support of the powerful case made for the independence of HealthWatch England by the noble Lord, Lord Patel, and by noble friends on these Benches. It is a mystery to me why, in the face of a genuine commitment by successive Governments to public and patient involvement, we

have made such a mess of it thus far. I am not one who looks back on the work of community health councils as some kind of nirvana. As someone who was briefly a chief officer of a CHC, I know that they were very patchy and variable in quality. However, they had a strong national voice, and I pay tribute to my noble friend Lord Harris of Haringey in that regard.

Since then, we have struggled. I think that the failure of the Commission for Patient and Public Involvement in Health has made successive Governments frightened of setting up one of these national organisations. It has put them off having a national body to support local groups, to help them to develop successfully and to help them when they are in difficulties, as well as provide a national, challenging voice for patients. Will HealthWatch England, as currently envisaged, be this missing national body? I am afraid that at present the answer is certainly no. As a committee of the CQC—an organisation for which I have the highest regard—it will not be independent or accountable to the patients and public it represents, and its links with local healthwatch organisations, which we will discuss later, will be very variable and often not sufficiently robust for them to be in full receipt of the amount and range of information that they need. We simply must have a proper governance structure with an independent, publicly appointed chair. Surely the independence of the whole organisation is essential to how it will provide the strong voice for patients that everyone involved say they want.

Lord Warner:

My Lords, it gives me great pleasure to follow that sterling contribution by my noble friend Lady Pitkeathley. The real problem with the Government's approach is that they really have not properly defined the functions of this body. One of the great strengths of this amendment is that it sets out what the functions of a truly independent body should be in this area. I make no defence of the previous Government's attempts to wrestle with this idea, but I think that we have continued to go backwards in this area since the days of community health councils, despite their patchiness.

I was very optimistic when the Government made their first announcements about healthwatch, and I was a great supporter of the brand name that they had created, which I thought was very powerful. Unfortunately, the functions that they have given it and the way they have set it within the CQC do not enable it to live up to the strength of that brand.

I was full of admiration for the creative way in which the noble Baronesses, Lady Cumberlege and Lady Jolly, loyally tried to make the sow's ear a bit more of a silk purse. However, it really does not cut the mustard. I think that we need to pay attention to the points made by my noble friend Lord Whitty, who emphasised very well the extent to which the model that the Government are pursuing has failed in a number of other areas of public policy. The Government should learn from that evidence and rethink this matter before we get to Third Reading.

I have one other point which concerns the rather spirited exchange that we had in Committee with the noble Baroness over the issue of campaigning. I shall return to that for a few moments. The whole point of having a body like healthwatch is to enable it to join forces with other people when there is a serious challenge to the public interest and to patients' interests in this area and allow it to campaign. I cannot see how it can be very easy for a committee of the CQC to join in that campaign. I asked the noble Baroness whether it would be able to campaign and, to her great credit, she said that yes, it would. Most of us who have knocked around the public sector for any length of time would find it very difficult to believe that a committee of the CQC would be able, despite what the noble Baroness says, to join in a campaign that was highly critical of the CQC. We need to be clear on whether it can campaign; and if it

can, I would like, as the noble Baroness said, a very convincing explanation of how it will be able to when it is sitting within the structure of the regulator and it is the regulator's deficiencies that it is campaigning against.

Baroness Murphy:

My Lords, I hope I shall be allowed to put a contrary point of view to that of the noble Lord, Lord Warner, and those who have tabled Amendment 223. First, I apologise for not contributing in Committee on this area; I happened to be away during the debates on this, but I read the reports with much interest.

This area of patient and public involvement is one that, as many noble Lords have said, we have struggled with for many years. I hark back to the CHCs with some nostalgia. They were a very mixed bag of organisations, but those that were good worked very effectively. I too pay tribute to the noble Lord, Lord Harris of Haringey, for the work that he did in supporting CHCs around London, which made my life an utter misery, as they were intended to do. I am very grateful for that.

Unfortunately, the arrangements that were put in place after their abolition have not worked. I say to the noble Lord, Lord Whitty, who is very persuasive in his arguments, that we have been there, done that and it did not work. As the noble Baroness, Lady Pitkeathley, said, the Commission for Patient and Public Involvement in Health was a total disaster. It was an extremely expensive quango—it was bureaucratic, totally isolated from other health bodies, the Department of Health did not know what it was up to and I do not think it knew what it was up to itself. It fell out with all the local patient and public forums. It was a disaster. It did not have any symbiotic relationships with those who make the health and social care services work; it was not in any way linked in with local authorities, which is a huge difference from these arrangements; and it seemed to me then that you had to have a structure in which all the core patient and public involvement organisations locally were crucially interlinked with what makes things work.

2.45 pm

We now have HealthWatch England and yesterday some of us had the benefit of listening to the way in which East Sussex County Council is tackling the healthwatch development, with the council linking it into the health and well-being boards, which seems to me to be crucial. Their development needs very sophisticated support from a central body that will have the resources and the links to be able to do that.

There is a very good reason for choosing CQC. With regard to quality, CQC is the eyes and ears of the Secretary of State. Healthwatch will be the local eyes and ears of the people on the way in which they receive healthcare and the way their healthcare should be designed. I think Winterbourne and Mid Staffordshire are very good examples: local initiatives, local patients and relatives could have taken their concerns to a local healthwatch and they could have had those local healthwatch concerns linked straight back into CQC through a committee. As the noble Baroness, Lady Cumberlege, has said, it is not a subcommittee; it is a formal committee. I very much like the amendments that link a local healthwatch, by elections, into this body and I am very supportive of the amendments of the noble Baroness, Lady Cumberlege. I think the Government structure is right but the way in which it works could benefit from some amendment.

Finally, I am willing to give the government structure support because I think it is a way forward but a bit of me thinks that we should ditch all these arrangements and instead give patients rights. If patients had rights they would not need a bureaucratic structure to make things work. If we have to have these

bureaucratic structures because we do not have what we need for patients in legislation, I think it is right that we should give this one a go. This has a much better chance than trying to recreate the commission, which is an independent quango. I think this will be a more economical and more effective way.

Baroness Wheeler:

My Lords, with an additional 68 government amendments tabled at the end of last week on the issue of HealthWatch England and the now much altered healthwatch organisations, it is somewhat of a challenge to work out exactly what the Government want from HealthWatch England and local healthwatch organisations. Why has not the Government's time since Committee stage been spent on trying to address the issues and concerns raised by noble Lords which would ensure that HealthWatch England and local healthwatch organisations have the real status and authority to do the job that we all recognise is required of them? Instead they have concentrated on compiling one of the most confusing additional sets of amendments that we have seen on this Bill, which will seriously undermine the ability of both the national and local organisations to act as an effective and robust watchdog for patients and the public.

The new local arrangements for healthwatch organisations provide a plethora of contradictions and confusions and we shall discuss those under a later group. Sadly, none of that addresses the continuing concern across the House and among key patients' groups and organisations about the HealthWatch-CQC relationship. Fortunately, Amendment 223A, from the noble Lord, Lord Patel, my noble friends Lord Harris, Lord Whitty and myself does. Those noble Lords have all made a coherent and powerful case for the amendment and for ensuring that HealthWatch England is independent. The amendment provides for a body corporate, with clear primary duties to represent the interests of patients and users of the National Health Service and of social care services, independent of any provider or regulator of those services. As well as powers to provide information and advice on the views of patients and standards of quality of care, the amendment provides HealthWatch England with powers to investigate complaints made by or on behalf of a patient or user of a local healthwatch organisation and to raise and investigate complaints relating to wider issues affecting patients or users in general.

The Government have said that they want to see HealthWatch England with genuine operational independence from CQC. However, attempts to do that by, for example, providing the majority membership of HealthWatch members on the HealthWatch board, or reassurances after the last debate in Committee in terms of HealthWatch England being able to speak out publicly in certain circumstances, even if their views conflict with its host body or government, miss the point. None of these small steps gives the unequivocal reassurance of independence that a robust patients' watchdog, acting in the interests of patients, must have. In the new market-dominated system that we will soon have, independence and a collective voice for patients is more vital than ever. In the end, it will come back to how the proposed measures will play out in practice and how conflicts of interest between HealthWatch England and the CQC, or indeed healthwatch organisations in the local authority, will be dealt with.

Most important of all is the issue of public perception, understanding and confidence in the independence of HealthWatch. It is important that HealthWatch is seen to be credible and truly independent, able to challenge and to scrutinise the work and decisions of the regulators, both CQC and Monitor. The niceties of whether there is a majority of HealthWatch members on the board, whether they can combine or exchange data and whether they are part of an organisation that the Secretary of State keeps under review will escape a patient, carer or representative who, for example, makes a complaint about how CQC has investigated care in a residential home, only to find that the body investigating the complaint or championing improved quality of care on behalf of patients is a committee of the CQC itself.

I hope that the noble Baroness will address these concerns: in particular, points that were repeatedly made about how the culture clash between healthwatch and the CQC will be addressed and managed; how we will stop CQC—in the words of the noble Lord, Lord Patel—"suffocating" HealthWatch England; how the potential serious conflict of interest will be dealt with; and how public faith, trust and confidence in healthwatch can be achieved under the relationship with the CQC, particularly in light of that body's major organisation and resource problems so starkly highlighted in the Department of Health's recent CQC performance and capability review.

In the debate on the duty of candour, the Minister referred to the CQC as an organisation that was remote from patients. We need an independent HealthWatch England and we need local healthwatch bodies that everyone can rely on to be genuine patient representatives. I am afraid that the Bill gives us neither.

Baroness Northover:

My Lords, this has been another excellent debate. I listened very carefully—as I did before—to the views expressed. Overall, there is clearly complete agreement on all sides of the House that the voice of patients and the public should be at the heart of the NHS. As the noble Lords, Lord Patel and Lord Harris, and the noble Baroness, Lady Masham, and others indicated, the history of how previous Governments tried to implement this is tortuous. The recent past has borne witness to a number of attempts to do it, and noble Lords referred to some of the problems. No attempt—not even Community Health Councils—managed to fulfil the worthy intentions of its architects, and we went from one to another.

As the noble Lord, Lord Patel, recognised—I appreciate his words—we seek here to take the strengths from past attempts, build on them and ameliorate the weaknesses as we develop our proposals for HealthWatch England. In the light of the comments of the noble Lord, Lord Harris, and as the noble Baroness, Lady Murphy, emphasised, it is worth remembering one of these previous attempts: the Commission for Patient and Public Involvement in Health. It was established in July 2003 and operated nationally and regionally, following regional government boundaries. Within five years it had been abolished after being seen to lack clout, to be too bureaucratic and too top-down for the public and those on the ground. Perhaps I may again remind the House of the judgment from the Health Select Committee's 2007 Report into Patient and Public Involvement in the NHS, which stated:

"The evidence we received was overwhelmingly critical of the Commission".

We are convinced that trying to recreate the commission is not the best way forward, and instead propose that HealthWatch England should be a statutory committee hosted—that was a very good description from the noble Lord, Lord Patel—by the CQC, which is a far more viable option.

I am well aware that this proposal has met with concern.

Lord Harris of Haringey:

My Lords—

Baroness Northover:

I will finish and then I will respond to the noble Lord if I need to. I am well aware that this proposal has met with concern from some quarters. I will explain why we are proposing this arrangement and why we do not feel that the case for having a separate body is stronger.

HealthWatch England will have clout. It will have a seat at the top table, taking centre stage in providing advice on patient and public views to the CQC, Monitor, English local authorities and the Secretary of State for Health. Noble Lords were right to say that Healthwatch England must influence all these bodies; that will be its responsibility. My noble friend Lady Jolly, too, made that clear. Each of these persons or bodies will have a duty to respond to the advice. Through local healthwatch, HealthWatch England will be closely linked to the views of people expressing views about the services that most directly impact on their lives. Our proposals for HealthWatch England will place it at the heart of the system—not at the top, divorced from the views of local people, as CPPIH turned out to be.

As a committee of CQC, HealthWatch England will be able to draw on the best of CQC's evidence base on quality and standards of care. The enthusiasm with which CQC wishes to learn via healthwatch is instructive. It will be helpful to CQC to have information coming from local healthwatch and HealthWatch England to CQC to alert it to problems such as those at Winterbourne View. This will give HealthWatch England a prominent position within a CQC that will have a strengthened role in assuring the safety and quality of health and adult social care services, and a strengthened focus on the concerns of health and social care consumers. This will ensure that from the outset HealthWatch England will have a greater presence and ability to influence than would a body established from scratch.

The Bill already contains significant safeguards to ensure that HealthWatch England will be able to operate effectively in that situation. For example, it will provide advice to a wide range of organisations. I have just mentioned central national organisations and local authorities. However, we listened carefully to concerns expressed in Committee about possible conflicts of interest between the CQC and HealthWatch England. This issue was raised again today. We therefore welcome Amendment 228, tabled by my noble friends Lady Cumberlege and Lady Jolly. It places duties on CQC and HealthWatch England to have regard to guidance from the Secretary of State about managing conflicts between these bodies. This is a sensible suggestion, and we are happy to support the amendment.

While acting independently, HealthWatch England must of course be accountable. Government Amendment 229 places a duty on it to send all local healthwatch organisations a copy of its annual report. It was the noble Lord, Lord Harris, who thought that this was a good idea and tabled an amendment to this effect in Committee. We agreed that it would help to secure the intended wide transparency and communication between HealthWatch England and local healthwatch. I am grateful to the noble Lord for flagging that up and suggesting the idea.

It is also important that local healthwatch—

Lord Harris of Haringey:

My Lords—

Baroness Northover:

No, I am going to continue, and if there are things that need to be dealt with at the end, I shall deal with them. It is also important that local healthwatch is able not only to provide information to HealthWatch England but to influence HealthWatch England's actions on matters raised locally that may have national importance. Various noble Lords made that point and they were quite right. We therefore welcome, and will support, the amendments of my noble friend Lady Tyler.

Lord Warner:

Are we allowed under the Standing Orders to hear the question of the noble Lord, Lord Harris? I would very much like to know what his point is.

Baroness Northover:

If I wish to continue with the thrust of my argument—as the noble Lord, Lord Warner, said in the previous debate—I can do so. At the moment it is better if I lay out my argument. If there are points of clarification that noble Lords want an answer on, I will be very happy to give way when I have completed my argument.

We welcome and support—

Baroness Jay of Paddington:

My Lords, I was not present when the noble Baroness had an exchange with the noble Lord, Lord Warner, on this matter. However, I have been in the House for 20 years and it is my widespread experience that of course the Minister is right to say that she must complete her argument. However, she has spoken for some minutes since the first intervention by the noble Lord, Lord Harris, and her argument has been well made.

3 pm

Baroness Northover:

The noble Lord, Lord Warner, wished to continue his argument against my noble friend Lord Phillips, and he did continue his argument.

Government Amendment 226ZG will enable HealthWatch England—

Lord Warner:

May I just correct the noble Baroness? I actually anticipated that the noble Lord, Lord Phillips, was going to jump up. I did not stop him jumping up. He chose to withdraw.

Baroness Rawlings:

May I just remind the noble Lord that the Companion sets out that a Member shall not speak twice on an amendment on Report.

Lord Hunt of Kings Heath:

My Lords, I have to say that we are seeing a reinterpretation of the normal procedure on Report. Nothing in the Companion prevents a noble Lord intervening and asking the Minister a short question. The fact is that by ploughing on and refusing to answer questions, the Minister is not serving the House appropriately.

Baroness Rawlings:

I shall just read from the Companion:

"A member of the House who is speaking may be interrupted with a brief question for clarification. Giving way accords with the traditions and customary courtesy of the House. It is, however, recognised that a member may justifiably refuse to give way, for instance, in the middle of an argument, or to repeated interruption, or in time-limited proceedings when time is short. Lengthy or frequent interventions should not be made, even with the consent of the member speaking".

Baroness Northover:

My Lords, it may help the House if I continue, but I am very happy to give way to noble Lords who wish to ask questions once I have gone through the various elements.

Government Amendment 226ZG will enable HealthWatch England to make recommendations of a general nature to local authorities about the making of arrangements for local healthwatch organisations and, where HealthWatch England is of the opinion that local healthwatch organisations' activities are not being carried out properly, to draw this to the attention of the local authority.

Amendment 226A, tabled by my noble friend Lady Cumberlege, would place a duty—I see Companions spinning all around the House, so while noble Lords are studying that—

Lord Harris of Haringey:

I want to ask a question, and I think the Minister has moved on to another point.

Baroness Northover:

I am very happy to take noble Lords' questions completely out of order, if need be, at the end if I have not addressed them.

Amendment 226A would place a duty on local healthwatch organisations to have regard to any advice or assistance provided by HealthWatch England under new Section 45A(2). We believe that this is too prescriptive. While we anticipate that local healthwatch organisations will welcome advice and assistance

from HealthWatch England, a blanket requirement to have regard to the advice and assistance does not seem appropriate.

The Government very much agree that it is very important to get the membership of HealthWatch England right, the better to ensure its independence, and I thank noble Lords for their contributions on this issue. The Bill already gives the Secretary of State the power to make regulations about the appointment of members, and it is a power that we intend to use. In Committee, we said that we would take away and consider the suggestions put forward by noble Lords. We have heard what was said and have undertaken a public consultation on these regulations. Noble Lords have flagged up that a number of noble Lords are interested in local elections from local healthwatch organisations to HealthWatch England, and that is one of the issues flagged up in that consultation.

The consultation closed on 2 March, and the responses are now being analysed. Government Amendments 225 and 226—I thank my noble friend Lady Cumberlege for adding her name to Amendment 226—would ensure that regulations are able to make adequate and appropriate provision about HealthWatch England's membership, including procedures for appointing members. It would also ensure that the regulations must require that the majority of members cannot be members of the CQC.

I now turn to aspects of the amendments relating to specific functions of HealthWatch England. It is interesting that some of these have not been flagged in the debate. Amendment 223A includes elements on patients' complaints, and I think it is important for noble Lords to be aware of some of the elements in it. I would point out that statutory mechanisms have been in place for the investigation of NHS and adult social care complaints for a number of years, and a great deal has recently been done to improve these arrangements.

In 2009, the previous Government—and I give credit to them—following considerable public consultation, introduced new complaints arrangements for the NHS and adult social care. These reforms placed a greater focus on the outcome of the complaint and on speeding up the process. Importantly, they placed emphasis on resolving complaints at local level with recourse to the independent Health Service Ombudsman, if appropriate, so that organisations were better able to learn from their mistakes and to use the information to improve future service delivery. While there is room for improvement in the local handling of complaints, we support the reforms put in place by the previous Government, and it remains this Government's view that complaints are best dealt with initially at local level. We wish to build upon these solid foundations. However, it is extremely important that the information that can be gathered from people's experience is fed in and that an individual complaint is taken forward in a largely satisfactory way.

The relevant part of Amendment 223A, which deals with complaints, could, we believe, fundamentally change the nature of HealthWatch, compromise its primary role of consumer champion, lead to confusion among service users, duplicate current arrangements and impact adversely upon the role of the Health Service Ombudsman.

The noble Lord, Lord Patel, laid out extremely clearly what HealthWatch England needs to do. It is extremely important that it is recognised as a very important body in the new structure and that it has input from practical experience. The noble Lord is quite right that information needs to come up from local level to national level and that it needs to feed in at every point of the new architecture. HealthWatch England needs to be part of what drives up standards, and it is different from the regulator. Many noble Lords emphasised that. It is indeed the voice of the people. All, including the Secretary of

State, have to listen to HealthWatch England, so it has a huge and important job. The noble Lord is quite right. It will not be buried in the CQC. Hosting is a very good way of describing its situation. It does not have to spend time and effort on back-office functions as CPPIH had to.

How Healthwatch England will be made up, its relationship to local HealthWatch and elections will be dealt with through regulations that will be informed by the consultation to which I have referred.

I now turn to the noble Lord, Lord Harris—

Lord Goldsmith:

When will we know when the noble Baroness has reached the end of the argument so that we can hear the question that the noble Lord, Lord Harris, wants to ask? I am worried that the noble Baroness thinks that argument means speech. That has never been my interpretation or my practice at the Dispatch Box.

Baroness Northover:

I am very happy to indicate when I think I have finished. I now come to answer some of the points made by the noble Lord, Lord Harris, or to address them at least. He may feel that I have not adequately answered them and, after that, he might like to hop up.

Lord Harris of Haringey:

That is not my style.

Baroness Northover:

I bear in mind a long history with the noble Lord, Lord Harris, that goes back quite a way and includes his very complimentary remarks when I gave my maiden speech in your Lordships' House. Noble Lords might want to look at them.

Both HealthWatch England and local healthwatch have statutory forms—perhaps the noble Lord, Lord Harris, might wish to hear this.

Lord Harris of Haringey:

I am multitasking, it is all right.

Baroness Northover:

I am so glad. Both have statutory forms and functions so they cannot simply disappear in the way that he fears. I pay credit to him for all his work in this area over many years.

It was a shame that the noble Lord, Lord Harris, was not at the meeting yesterday to which the noble Baroness, Lady Murphy, has referred. With his formidable local government experience, I am quite surprised that he does not welcome the local authority involvement in the arrangements that we are putting forward. Had he been there yesterday, he would have heard the enthusiasm of the LGA, the chief

executive of East Sussex County Council and others for their new involvement in health services. They are extremely keen to be best informed by flourishing local healthwatches. As they take on their new task, they see having that information as very important.

The noble Lord, Lord Harris, asked about the funding formula. Funding for local healthwatch will continue in a very similar fashion to LINks. It will be allocated primarily through the formula-based grant. Like LINks, this funding will not be ring-fenced, but each local authority's allocation through the formula-based grants will be publicly available. I hope that that is of help to him. In addition, local healthwatch will receive additional funding through the DH learning disabilities and NHS reform grant.

I have various other responses to various other people, but perhaps the noble Lord wishes to put a question to me.

Lord Harris of Haringey:

I am enormously grateful to the noble Baroness. She has answered some of the questions that I put. However, the question I wanted to ask related to her remarks about 15 minutes ago, when her argument seemed to be that this amendment recreated the former Commission for Patient and Public Involvement in Health. Does she acknowledge that this is a completely different structure, because it would be derived from the bottom up, with the support of local healthwatch organisations? What is more, it would not have to be encumbered by the bureaucracy that the Department of Health formerly imposed on that commission. It is a completely different structure.

Baroness Northover:

I hear what the noble Lord says, but if he remembers the relationship and the aims of CPPIH, a lot of them echo the arguments that he has been making about such a structure. We may simply have to differ. The Government are very keen to have a structure that is up and running immediately, linking to, plugged into and influencing the national bodies that it needs to, and that it is not spending its time on its central structure. That is why this arrangement has been sought and that is the philosophy behind it.

The noble Baroness, Lady Masham, raised a number of issues, some of which will be considered in the next grouping. Perhaps I could come back to them then so that I do not take too long. I am astonished and delighted to see so many noble Lords who are interested in what I have to say on this.

My noble friend Lady Jolly asked about information-gathering, and she is absolutely right. In many ways this bears out how the CQC is very useful in this regard. By being hosted within the CQC, HealthWatch England will gain support from CQC expertise on the best methods of gathering and making the most of intelligence from local healthwatch. As part of HealthWatch England's set-up plan, the CQC has dedicated resources to identify and develop the system that will support information flow between HealthWatch England and local healthwatch. I take on board very strongly what she said about the need for that information to be produced in a form that can be generalised and applied nationally, and that there are not lots of disparate bits of information that cannot be put together.

The noble Lord, Lord Warner, asked again about campaigning. I said in Committee that HealthWatch England and local healthwatch can campaign. I followed that up with a letter confirming that, which I hope he got—but perhaps he did not—and I reiterate it here. I hope that that is of help to the noble Lord.

I thought that the vision of the noble Lord, Lord Patel, was exemplary. Being a statutory committee within the CQC ensures that HealthWatch England has its own statutory form while being hosted by the CQC. We think that this distinct identity, rather than just being part of the CQC without a specific form, will help HealthWatch England. That is why that is there.

The noble Lord, Lord Patel, made an excellent point about the public being able to contact HealthWatch England directly rather than through the CQC. I can confirm that this idea is being actively discussed as part of HealthWatch England's establishment. It is very important that information can go straight in.

The noble Lord, Lord Patel, made a number of statements with which I completely agree. What he said HealthWatch England needed to be is what we intend it to be. While being hosted by the CQC, HealthWatch England will have its own statutory functions and relationships with other bodies, and a range of statutory safeguards to ensure that it is free to act independently. I am pleased that the noble Lord made those points and I am very happy to assure him that that is the case. It is worth remembering that if HealthWatch England were significantly to fail to fulfil its functions, or not fulfil them properly—for example, in being the national voice of patients—the Secretary of State could intervene, so that protection is offered as well.

The noble Baroness, Lady Murphy, put it very nicely when she said that HealthWatch England and local healthwatch will be "the eyes and ears" of patients and the public. I hear scepticism from some but that is the intention, and it is building on the experience of what worked and what did not work in the past. HealthWatch England must be heard in all the key fora, nationally feeding information through from local areas. It has statutory protection to ensure that it can do its job without being weighed down with bureaucracy.

I am very happy at this point to be interrupted by anyone on anything. I do not think that anyone wants to interrupt me, in which case I hope noble Lords will be reassured that the Bill, with the amendments that we have proposed, provides the safeguards that are being sought, which I fully understand. We are coming from the same place. We want to make sure that the public and patient voice is heard, which is why the Government have made these proposals in the way that they have for HealthWatch England and for local healthwatch organisations. I trust that noble Lords will feel that independence is secured by those statutory protections and that the noble Lord will be happy to withdraw his amendment.

Baroness Scotland of Asthal:

My Lords, now that the noble Baroness has sat down, perhaps I may raise a point of order. I have to tell the House that I found the exhibition we have just had rather extraordinary. I have not been in this House for very long. Noble Lords will know that I came to the House only in 1997 but I had an opportunity to answer for the then Government from the Front Bench. It is certainly my experience that what would normally happen in this House is that if a noble Lord wanted to intervene, particularly at this stage in the proceedings, that person would be allowed to complete the sentence or the paragraph and would then sit down. Bearing in mind that it would be regrettable if this should become a pattern, I wonder whether we could ask the usual channels to look at these issues so that we will have clarity if we are about to adopt a new procedure.

Noble Lords:

Hear, hear.

Baroness Northover:

In response to the noble and learned Baroness, if I was in any way discourteous, I apologise but I hope that I gave the opportunity at the end for anybody who had further questions please to put them to me.

Lord Patel:

My Lords, I thank the noble Baroness for her response. I think that the conversation, or lack of it, was unfortunate because not only did it not allow people to put their questions at the correct time, it probably interrupted the noble Baroness's flow of speech and thoughts. Having said that, I am flattered by her compliments on what I had to say. However, she did not address the fundamental point when I speak for those who are concerned about public and patient involvement. She has said that the statute provides that HealthWatch England will be a committee. That is quite different from a statute which provides that HealthWatch England will be independent. Again, there is a vast difference. Also, in terms of its functions, there is nothing in the statute that says that HealthWatch England will have the power to ask for or demand information in the interests of patients and the public in order to demonstrate that the quality of care provided is not adequate. Although the statute recognises that HealthWatch England will have strong relationships with Monitor, the Commissioning Board and so on, it will not have the power in statute to demand that independently. It has the power in statute to work through the CQC to ask for that. That is what concerns people outside. Indeed, while listening to the debate I was getting e-mails saying, "This is not what we asked for and it is not what we want. This does not give us confidence that we will have the necessary authority to respond".

The one lone voice in the wilderness, although it might have been loud, came from the noble Baroness, Lady Murphy. She suggested that this is ideal because of one very good chief executive in mid-Sussex. I wish we could clone her. For every one that is successful there will be 10 failures, and it is those failures which a good, powerful and independent HealthWatch England would be able to address when a local healthwatch organisation fails because the chief executive is not being supportive.

There are many issues here. If we are serious about giving the public and patients a strong voice, the Government must recognise that they need strong support and that they need it for a long time. Although I have not been associated with patient and public organisations in England, I have been involved with them on three different occasions. In fact, I set up one of them. I should say to the Minister that I thought I did a brilliant job. I gave it all the powers one could possibly give in terms of setting standards, inspecting hospitals, writing reports and criticising every service. It worked well, but it fell down because its strong support was withdrawn. It is important to recognise that if we are serious about giving patients and the public a strong voice, we need to give them status. We should not treat them like juveniles who do not understand the issues. They should be treated with the respect they deserve and be given strong support.

Unless the Minister is about to tell me that suddenly she is hearing a different message and that we can have a further conversation and another opportunity to look at this, I am afraid that, for those outside who are concerned about this, I will have to seek the opinion of the House.

Division on Amendment 223A

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Amendment 224 not moved.

Amendments 225 to 226ZG

Moved by

Earl Howe

225: Clause 180, page 176, leave out lines 26 to 29

226: Clause 180, page 176, line 30, leave out subsection (3) and insert—

"(3) After sub-paragraph (5) insert—

"(5A) Regulations under sub-paragraph (1A) must make provision requiring a person who has power to appoint a member of the Healthwatch England committee to secure that a majority of the members of the committee are not members of the Commission.

(5B) Regulations under sub-paragraph (1A) may specify other results which a person who has power to appoint a member of the committee must secure.

(5C) Regulations under sub-paragraph (1A) may, in particular, make provision as to—

(a) eligibility for appointment;

(b) procedures for selecting or proposing persons for appointment.

(5D) Regulations under sub-paragraph (1A) may, in particular, make provision as to—

(a) the removal or suspension of members of the committee;

(b) the payment of remuneration and allowances to members.”.”

226ZA: Clause 180, page 176, line 34, leave out “Advice given by Healthwatch England” and insert “Healthwatch England and Local Healthwatch organisations”

226ZB: Clause 180, page 176, line 36, after “(2)” insert “, (2A), (2B)”

226ZC: Clause 180, page 177, line 2, leave out “advice on” and insert “general advice”

226ZD: Clause 180, page 177, line 3, leave out “or in pursuance of”

226ZE: Clause 180, page 177, line 5, at end insert—

“(aa) the making of arrangements in pursuance of arrangements made under section 221(1) of that Act (see section 222(2B) of that Act);”

226ZF: Clause 180, page 177, line 6, leave out “by the organisations”

226ZG: Clause 180, page 177, line 7, at end insert—

“(2A) The function in this subsection is a power to make recommendations of a general nature to English local authorities about the making of arrangements under section 221(1) of that Act.

(2B) The function in this subsection is a power, where the Healthwatch England committee is of the opinion that the activities specified in section 221(2) of that Act are not being carried on properly in an English local authority’s area, to give the authority concerned written notice of its opinion.”

Amendments 225 to 226ZG agreed.

Amendment 226A not moved.

Amendment 227

Moved by

Baroness Massey of Darwen

227: Clause 180, page 177, line 10, leave out "people" and insert "adults and children"

Baroness Massey of Darwen:

My Lords, first I apologise on behalf of the noble Baroness, Lady Tyler, who cannot be here today due to another speaking engagement. My amendments in this group seek to cover listening to the voice of the child in whatever structures or systems we end up with in the course of the Bill. The voice of the child is clearly important and I wish to address this one issue today. This is not just about adult patients among the public but children, too. I make explicit that HealthWatch England's advice on the views of patients and members of the public must also refer to the views of children. These amendments are supported by numerous children's groups and by the Royal College of Paediatrics and Child Health.

Children's involvement in healthwatch organisations was debated in Committee on 15 December. The Government acknowledged that,

"local healthwatch needs to represent the views of all people within the local population, including children and young people".

However, they rejected amendments that cited children as a specific group to be reached by healthwatch, saying,

"if you list one group you are in danger, therefore, of excluding others".

Taking account of those concerns, I have tabled a new set of amendments, drafted to make explicit that the remit of healthwatch includes children without inadvertently suggesting that they should take preference over adults or any other group. In Committee, the Government offered assurance that when,

"the pathfinder local healthwatch organisations come into play, we will ensure that what noble Lords have said is flagged up to them".—[Official Report, 15/12/11; col. 1499.]

I am concerned that flagging up the issue to emerging local healthwatch organisations will not be sufficient. I seek further assurances that consultation of children and children's rights will be addressed. There must be a clearer steer at national level to make sure that the voices of children and young people are heard in the health system. I call on the Government to do three things. First, they should develop and disseminate guidance for local healthwatch organisations on effective engagement with children, drawing on pathfinders' experiences. Secondly, they should conduct a review on how HealthWatch England and the local healthwatch organisations have involved children in their work two years after commencement. Thirdly, they should appoint a champion for children within HealthWatch England to oversee this work and drive forward standards on children's engagement and decision-making.

This Bill is the first opportunity that parliamentarians have had to respond to the findings of the Kennedy review, published in September 2010, Getting it Right for Children and Young People. The Government response to the review accepted Sir Ian Kennedy's powerful arguments about the need to engage children in the NHS, saying:

"In the past, the NHS was not always set up to put the needs of patients and the public first. Too often patients were expected to fit around services rather than services around patients. Nowhere was this more the case than for children, young people and their families … If we are to meet the needs of children,

young people, families and carers, it is vital that we listen to them in designing services, gather information on their experiences and priorities, provide them with the accessible information that they need to make choices about their care, and involve them in decision making".

In a welcome move, the Government promised in December 2010 to give due consideration to the Convention on the Rights of the Child when making new law on policy. As a signatory to that convention, the UK must take all possible steps fully to realise the rights and freedoms in the convention, including Article 12, which says that children should have a say in all issues affecting them and that their views should be,

"given due weight in accordance with the age and maturity of the child".

The international monitoring body for the CRC, the UN Committee on the Rights of the Child, has been clear that the article applies to collective decision-making processes as well as matters affecting the individual child. Among its main recommendations was that the UK should promote respect for the views of the child. My amendments would implement recommendations in relation to children's healthcare.

Local healthwatch will take forward the work done by local involvement networks, or LINks, in seeking the views of local service users in health and social care and involving them in the development of services. I urge noble Lords to amend the Bill today to make it clear that HealthWatch England and the local healthwatch should effectively involve children in their work.

A great deal of research has been done on this, including by the National Children's Bureau, which found that not all LINks understood that engaging children was part of their official remit. The review of law policy and practice by Participation Works found that although 41 per cent of GP practices had patient participation groups there was no evidence of children's engagement in these forums.

The Council for Disabled Children document, Managing My Way, researched with disabled children and healthcare professionals, found that the majority of professionals felt they did not receive enough training to develop their skills in communicating with young people, especially those who have different communication needs. Research by the Institute of Child Health has found that the views of under-16s were sought in only one of 38 national surveys of patient experience in the NHS between 2001 and 2011. Young Minds found that in 80 per cent of cases young people were not involved in shaping local services. The Royal College of Paediatrics and Child Health and the NHS Confederation recently published a guide to involving children and young people in health services, which underlined the key role that children can and should have in planning and service delivery. The report says that,

"there is little incentive for organisations to systematically ensure a good and consistent standard of service for children and young people",

unless they are involved in those services.

I look forward to the Minister's response, particularly the three issues—guidance to the local healthwatch, a review of the involvement of children in healthwatch and a champion for children in healthwatch. I beg to move.

Baroness Finlay of Llandaff:

My Lords, I added my name to these amendments because I agree with all the comments that the noble Baroness has just made. Children and young people are stakeholders in health. They are also the future of our nation. They may be dependent at the moment while they are children and young people, but they are the leaders of the future. They have specific needs and their own views about they way that they are treated. If they are not listened to and considered in the way that services are planned, they will continue to feel that they are not valued as much as they should be by healthcare itself and that healthcare is not really placing their needs at its heart in provision.

In the Royal College of Paediatrics and Child Health handbook called My Right to the Highest Standard of Health, Professor Terence Stephenson wrote,

"we cannot afford to continue as we are. The health of our children is at stake and we need to address real issues, with real change that brings about real positive impact on the health outcomes for children and young people".

Children and young people must no longer be treated as passive recipients of services. It is by feeling valued that their well-being will be increased. Particularly in prevention in healthcare, the engagement of young people is critical to ensure that health improvement policies and the whole public health agenda are taken up by the very group of people who will get the most benefit from them and will be most harmed if public health measures fail—that is, those who are in adolescence and about to transition into early adulthood.

Until now, unfortunately, as has already been said, some LINks have not seen fit for their remit to include children. Through these amendments, I seek reassurance from the Minister that healthwatch will be provided with the resources, knowledge and capacity to involve children and young people effectively and will therefore be able to represent their needs and interests on a local and national level. It cannot be viewed as a tokenistic voice.

I shall cite an unfortunate example that the RCPCH has brought to my attention. A large teaching hospital trust was preparing an application for foundation trust status. As part of the process it was asked to show evidence of patient and public participation, including the involvement of children and young people. In response to this, the trust asked for some young people who were in-patients to receive a patient satisfaction questionnaire. A number of young people completed the questionnaire as requested, but the results were not used during the foundation trust application as the opinions voiced by the young people were at odds with the views of the management team. That is a clear example of tokenistic consultation but then doing nothing about the answers that are received.

Children are able to contribute in a very generous way to the shaping of healthcare services because they will comment quite openly, not only on what they need and what would make their journey through health better but on the experience of others that they encounter on the way. Children and young people with chronic conditions will form close friendships and bonds with other patients in their cohort, whom they will meet regularly when they attend different treatment sessions, and will be concerned about the welfare of those other children. In the days when I was working in paediatrics, I recall vividly how children in the leukaemic unit would ask about the welfare of other children. They would want to know what had happened to a child who had died and to talk about where that child had gone. One little boy

commented on another, “At least now he’ll be able to do what he always wanted to do. He’ll be playing football, but it’ll be in heaven”.

Children know what they need, where they want to go and how they want to be involved and consulted. The whole tenor of our health services can be greatly improved by actively seeking out their views and acting on them, however difficult and uncomfortable those views might be.

Baroness Masham of Ilton:

My Lords, I also have my name to the two amendments in this group. Children need protection and the support that my noble friend Lady Finlay has just talked about. So much more should be done for children, but the big problem is that they fall under so many different departments which are far too isolated. I am thinking now of the young people who are at risk from drugs and alcohol. I went to a presentation last week where there were photographs up of young children who had died from a combination of drugs and alcohol. So much should be done.

I hope that the Minister will answer my question from the previous debate about children and the risks that they face, taking Baby P as an example. Again, many departments came in and he fell through the net: health, the police, child protection and local authorities. They should be working together for children. We really need to protect them.

Lord Warner:

My Lords, I speak from a background of having been a director of social services and being involved in reforming youth justice. Collectively, the adult world is very bad at representing the needs of children to service providers. It would be a modest but important change in this legislation if we brought out that the term “people” does include adults and children. A lot of people in the adult world simply assume that “people” means “adults” and does not mean “children”. We see in the NHS, for example, particularly for the teenage years, that services are often provided in a way which is almost bound to deter engagement and involvement by young people in receiving those services and in dealing with some of the problems that they have.

We need to change the culture. We must ensure that in the new healthwatch system—whether it is the one that some of us would have liked or the one that there will actually be—people are sensitive to the needs of children, particularly at the local healthwatch level, and that those needs are not overlooked. It is not just a matter of making children feel better and that they are being listened to. It is actually about how we can get the services shaped to head off at a much earlier stage some of the trouble that is looming for many of these children, in terms of obesity, drugs, sexual health and unwanted pregnancy. I hope that the Government will listen sympathetically to this and move the kind of amendment that my noble friend Lady Massey has moved so ably.

Lord Low of Dalston:

My Lords, I cannot speak with anything like the authority of the noble Baroness, Lady Finlay. Few of us can. The noble Baroness, Lady Massey, has obviously been working off the same brief that I have been looking at, so there is little that I can add to what she said. However, I was struck by the research findings that she told us about, which make clear the lack of attention that is paid to the involvement of children. I note also that there were concerns expressed around the involvement of children in patient and public

voice mechanisms in the NHS. These concerns were reflected in the report of the Future Forum. Therefore, I think there is every reason to make the involvement of children explicit in relation to the Bill.

Baroness Thornton:

My Lords, we welcome the amendments. Anxiety has been expressed by children's organisations on two fronts throughout the course of the Bill. One is that the fragmentation and reorganisation proposed in the Bill mean that the safeguarding of children's health may be lost in some way. The second is that it is not clear that children's voices will be heard, which is the subject of these two very modest amendments. I hope that the Government will accept them. I cannot see any reason why they should not.

Baroness Northover:

My Lords, we have great sympathy with Amendments 227 and 233. It is indeed vital that the voice of children is sought throughout the system and we agree that HealthWatch has a key role to play in this at both national and local levels. I thank the noble Baroness, Lady Massey, for the important points to which she and others drew attention. As we know, the noble Baroness has a long record of promoting the rights of children.

We are aware that some LINks have, as the noble Baronesses, Lady Massey and Lady Finlay, said, struggled to engage fully with children and certain groups of adults. It is very important that local healthwatch learns from that and is clear about the importance of engaging with children and young people. However, we do not feel that we should specify particular sections of the population in the Bill, although local healthwatch and HealthWatch England need to seek out views, especially of those who are hard to reach.

The noble Baroness, Lady Massey, spoke about guidance on engagement with children for local healthwatch. I can assure her that professionals and service users' representatives are, through the Children and Young People's Health Outcomes Forum, currently working with the Department of Health to develop a children and young people's health outcomes strategy and to ensure that detailed design and development work is done with children and young people in mind. This includes HealthWatch. I can confirm that five local healthwatch pathfinders include a focus on children and young people. We hope to learn from that and that other local healthwatch organisations will learn from their experience. HealthWatch England will be able to use the work of the children and young people's health outcomes strategy, the experience of the pathfinders and wider development work to develop advice and assistance to local healthwatch organisations on effective engagement with children, young people and their families.

The noble Baroness, Lady Massey, also suggested that we conduct a review of how HealthWatch England and local healthwatch involve children in their work. That is a very valuable idea. We fully agree that we should look at reviewing this, perhaps after three years of operation, to see how effectively HealthWatch England and local healthwatch have involved children and other hard-to-reach groups in their work.

The noble Baroness also suggested having a champion for children within HealthWatch England to drive forward children's engagement. I hope I have reassured her that involving children will be a priority for HealthWatch England and local healthwatch. However, we believe that it would not be appropriate to have a children's champion or, indeed, a specific representative for any patient group.

In the next group of amendments we will look at a definition of "people" that came from my noble friend Lady Jolly. That rather bears out what many noble Lords have said about making sure that we do not have just a narrow focus but recognise that we must not overlook groups such as children or hard-to-reach adults which have not necessarily had their voices heard in the past.

I was asked by the noble Baroness, Lady Finlay, whether HealthWatch will have the resources to involve children fully. Yes, it will. Representing people of all ages will be a core function of HealthWatch and will be resourced at a level to ensure that it can fulfil its duties and functions. The noble Baroness, Lady Masham, spoke strongly about how important it is to involve children and young adults, as did the noble Baroness, Lady Finlay, and others. I very much agree and feel that HealthWatch offers great potential to improve involvement in this area. Throughout everything that we are doing we are seeking to join up and integrate in the important way that she flagged up in her comments.

Although I cannot take forward the idea of the champion, nevertheless we understand and take on board the other suggestions that the noble Baroness, Lady Massey, has made. We are keen that HealthWatch England and local healthwatch groups reach out to a number of groups whose voices have not necessarily been heard in the past. Even if the noble Baroness is slightly disappointed with that response, I hope that with these other reassurances she will feel able to withdraw the amendment.

4 pm

Baroness Finlay of Llandaff:

Before the noble Baroness sits down, does she recognise that the legal status of children differs from that of adults? That is why they do not fall into the same category as many other vulnerable groups. Children do not reach the age of majority until they are 18, although they can consent to some things at 16. Therefore, they are always dependent on a responsible adult to speak for them or to open the door for them, as it were. They cannot form a group in the way that others in the population can to speak up for their rights and what they need. Will the noble Baroness reassure us that the Government recognise that the legal status of children differs from that of adults, and that if these amendments are not to be accepted, careful consideration will be given as to how that can be made explicit in the Bill before it completes its passage?

Baroness Northover:

The noble Baroness made a poignant case for why children need to be listened to. I hope I can reassure her that HealthWatch England and local healthwatch have a responsibility to hear the voices of everyone, whatever their age. I accept what she says about the legal status of children. However, as she made very obvious, that does not mean to say that we cannot hear their voices and take very seriously their perception of how they can best be treated.

Baroness Massey of Darwen:

My Lords, I thank all noble Lords who have taken part in the debate on this amendment. I am aware that there is a very powerful lobby in this House which supports the voice of the child in all matters and supports children's welfare generally. There is also a very powerful lobby outside of children's organisations that are dedicated to providing children with what they need.

I thank the noble Baroness for the reassurances that she has given. However, I stress that the research I quoted contains clear evidence that the voice of the child is often overlooked. We must be vigilant that it is not overlooked in the future. One of my three queries to the Government concerned disseminating guidance. I fully accept that there will be a health outcomes strategy for children. However, we have to keep an eye on that and see what happens in relation to the contribution of children's voices to carrying out that strategy.

The noble Baroness said that there would be a review of how HealthWatch England and local healthwatch involved children. I suggest that two years after commencement is a sufficiently long period. I am disappointed about the champion issue because without advocacy some vulnerable groups will be neglected, which is never a good thing. I will follow up these issues with the Government. In the mean time, I beg leave to withdraw the amendment.

Amendment 227 withdrawn.

Amendment 227A not moved.

Amendment 228

Moved by

Baroness Cumberlege

228: Clause 180, page 177, line 35, at end insert—

"45AA Conflicts of interest

(1) In making arrangements under section 45A(1), the Commission must have regard to any conflicts guidance issued by the Secretary of State.

(2) In exercising functions on behalf of the Commission, the Healthwatch England committee must have regard to any conflicts guidance issued by the Secretary of State.

(3) In this section, "conflicts guidance" means guidance about managing conflicts between—

(a) the exercise of functions by the Commission, and

(b) the exercise of functions by the Healthwatch England committee on the Commission's behalf."

Amendment 228 agreed.

Amendment 229

Moved by

Earl Howe

229: Clause 180, page 177, line 47, at end insert "and to every Local Healthwatch organisation"

Amendment 229 agreed.

Amendment 229A

Moved by

Baroness Jolly

229A: Clause 180, page 178, line 2, at end insert—

"(3A) Where a recommendation is made to the committee under section 221(2)(ga) of the Local Government and Public Involvement in Health Act 2007 (reports under subsection (3)), the committee must have regard to the recommendation."

Amendment 229A agreed.

Amendment 230

Moved by

Earl Howe

230: Clause 180, page 179, line 5, leave out subsection (14) and insert—

"(14) The Healthwatch England committee is to be treated for the purposes of section 2(1) of the Public Bodies (Admission to Meetings) Act 1960 as a body that includes all the members of the Care Quality Commission."

Amendment 230 agreed.

Amendment 231 not moved.

Amendment 231ZA had been withdrawn from the Marshalled List.

Amendment 231ZB had been retabled as Amendment 234ZA.

Amendment 231A

Moved by

Baroness Bakewell

231A: After Clause 180, insert the following new Clause—

"Healthwatch England's Commissioner for Older People

(1) The Health and Social Care Act 2008 is amended as follows.

(2) In Chapter 3 of Part 1 (quality of health and social care), before section 46 and the preceding cross-heading insert—

"Healthwatch England's Commissioner for Older People

Healthwatch England's Commissioner for Older People

(1) A member of Healthwatch England shall be designated as the Commissioner for Older People in England.

(2) The Commissioner shall exercise their functions independent of their role as a member of Healthwatch England.

(3) The general functions of the Commissioner shall be to consult with and garner the opinions of older people, and to represent those opinions in all arenas of public discourse including Parliament.

(4) The Commissioner shall be free to set its own parameters within the broad context of monitoring institutions.

(5) The Commissioner must encourage the involvement of older people in the work of the Commissioner.

(6) The Commissioner must, in a particular, take reasonable steps to listen to and consult with older people on the work to be undertaken by the Commissioner.""

Baroness Bakewell:

My Lords, the amendment calls for a commissioner for older people. When I moved such an amendment in Committee, I suggested the role as a freestanding one. In this amendment, I seek to have it subsumed into the agenda of HealthWatch England, requiring a commissioner to be a member of HealthWatch England but exercising this function entirely independently.

After a fruitful meeting with the noble Earl, Lord Howe, I realise that there are certain limitations around this suggestion—also put to me by other Members of this House—to which I shall come in a moment. However, first let me briefly revise the need for such a position. On every hand, the calls get stronger for the case of the old to be heard. Earlier this week, some 1,000 older and disabled people came to lobby their MPs about the crisis in social care. The Care and Support Alliance, which organised the event, represents more than 60 charities and organisations across the social care and health sectors. MPs heard stories from some of the estimated 800,000 people needing care who are currently not receiving it. Recent reports from the Equality and Human Rights Commission and the Commission on Dignity in Care have reported neglect and abuse. All this since the Committee stage of the Bill. Older patients take up most of the beds in our hospitals where they are patronisingly accused of bed blocking. Given the demographics of a growing population, this situation is set to get worse. No one now doubts that there is a growing national crisis.

All these commissions and reports are fine and often very thorough. However, they tell us about "them", the old—a category of the population who need to be dealt with and have their needs met. But the old

are not a lumpen mass; they are each as highly individual as those in any other age group. They need someone to speak in different terms and in a different tone about, "what we need" and, "what I am asking for". A commissioner for older people would answer that need and relate directly to the personal stories that arrived in my post bag when I was the Voice of Older People. I feel confident in saying this because Wales already has an Older People's Commissioner—Ruth Marks, who has a fine record of touring the country, visiting care homes, day centres and individuals, and bringing individual concerns to bear on the Government in Cardiff.

Let me now come to the limitations of this role. The NHS Future Forum report states:

"If the fundamental purpose of the Government's proposed changes to NHS—putting the patient first—is to be made a reality, the system that emerges must be grounded in systematic patient involvement".

The problem here is the word, "patient". Older people are indeed patients, but their needs extend much further than this. As the noble Earl discussed with me in our very useful meeting, the needs of the old extend much further. They extend to matters that concern not only health but work and pensions, housing and transport. They extend across all other activities of life and all departments of government. I am wary of confining the function too tightly within the health Bill agenda. I take the noble Earl's argument, and other Members of the House have expressed similar concerns. I would value their views on this matter put on the record.

However, we have to start somewhere. Some initiative has to start the ball rolling. People want their voice, our voice, a voice to speak out about our needs. The impulse to establish such a post is right, but the move to have a commissioner for older people has to be triggered somewhere. I hope that it will be triggered by the amendment. I beg to move.

Lord Hunt of Kings Heath:

My Lords, my noble friend has made a powerful case for having a champion for older people to look not just at the impact of decisions made in the NHS but going much wider. She is right to refer to pejorative remarks such as bed-blocking being very insensitive to old people. We face a considerable challenge within the health service to ensure that we are sensitive and reflect that there is huge demand from frail older people which is not being met as effectively as we would wish.

My noble friend said that the amendment may not be perfectly formed but that we have to start somewhere. I wonder whether the noble Earl, late on this Thursday afternoon, might give some comfort. After all, it would not be impossible within HealthWatch England to have a designated person with responsibility for overseeing—or, if you like, monitoring—services for older people. It could be well worth exploring whether the thought behind my noble friend's amendment is worth pursuing.

Baroness Barker:

I just make two or three simple points. I have enormous sympathy with the amendment of the noble Baroness, Lady Bakewell. My party's policy is in favour of the establishment of an older people's commissioner in England, building on the interesting work that has been done in Wales. I have a great deal of sympathy with what she is trying to do. She made the argument that one has to start somewhere. I disagree with her that this is the right place to start. If one had to start somewhere, it should be in social care. The deficiencies in social care matter more to more older people than those in health.

Having said that, the noble Lord, Lord Hunt of Kings Heath, is right. Given that older people are by far the biggest users of NHS services, it would be remarkable if HealthWatch were not to include people with the expertise to follow up older people's issues.

My deep resistance stems from two things. First, I think that the biggest challenge set out in the Bill, which has been overlooked, which is why I take the opportunity to mention it again, is the challenge for the NHS to get to grips with social care and enabling older people—all people, but, by definition, older people—to live healthier lives for longer and not to wait until they turn up in the NHS.

However, my fundamental point is that I have talked to lots of older people over the years and I believe that old age has to be about more than the health service. If the only government recognition that older people have is the right to have someone to complain about the health service, I think we will be in danger of medicalising old age and inadvertently removing the full experience, wealth creativity and knowledge that older people bring to many aspects of life. I know that, given her former role, the noble Baroness, Lady Bakewell, would not intend that. Therefore, I hope that she will accept my support for what she is trying to do and my reservations about the way that she is trying to do it with this amendment.

4.15 pm

Baroness Masham of Ilton:

My Lords, perhaps I may ask a question following the speech of the noble Baroness, Lady Barker. Does healthwatch not cover health and social care? If it does, the noble Baroness, Lady Bakewell, has a strong point.

Earl Howe:

My Lords, while, for reasons which I shall explain later, I do not feel able to accept this amendment, I say immediately to the noble Baroness that she has raised a very important issue with which the Government are in complete sympathy.

It is important for older people to have a strong voice to champion their interests and to ensure that their needs are addressed in public services. Both I and my honourable friend the Minister of State for Care Services have met the noble Baroness over recent months to discuss this issue and have been struck forcefully by the powerful case that she has made. As she is aware, my honourable friend would like to continue these discussions with her, as we are particularly grateful for the expertise that she brings to this area.

I am sure noble Lords will agree that older people are affected by a wide range of issues—not only health and social care but areas of policy such as housing and pensions. The Government recognise this. The UK Advisory Forum on Ageing, co-chaired by the Minister of State for Care Services and the Minister of State for Pensions, provides advice across government on the additional steps that they and their partners need to take to improve well-being and independence in later life.

In health, a range of functions in relation to older people are already carried out in this country. That should not surprise us because we all know that a very large proportion of the NHS budget is accounted for by healthcare delivered to the elderly. The Department of Health is pursuing a number of initiatives to improve the care of older people in hospitals, care homes and other settings. These initiatives cover all

stages of the care pathway—from helping individuals to stay healthy and to stay in the community all the way through to end-of-life care. For example, the department already has a National Clinical Director for Older People, Professor David Oliver, whose remit is to promote the better care of older people across the NHS and social services, and to provide clinical leadership for cross-government work on older people.

My noble friend Lady Barker rightly stressed the key role of social care in relation to older people. Looking across the spectrum of health and social care, each health and well-being board will be required to develop a joint strategic needs assessment, identifying the current and future needs of the local population, and a joint health and well-being strategy to set out how those needs will be met. I can say to the noble Baroness, Lady Bakewell, that it is intended that health and well-being boards will bring together the key local commissioners to enable them, first, to consider the total resource available to improve their population's health and well-being, and then to come to a joint understanding about how those resources can best be invested. This will undoubtedly help to encourage a more integrated local service which is better able to meet the needs of older people by joining up NHS and social care services. I hope that that offers some reassurance to the noble Baroness that the voice and needs of older people in health is absolutely a priority for this Government.

Amendment 231A proposes that the role of commissioner for older people should fall on a member of HealthWatch England. I am afraid that I cannot agree that that would be an effective approach. The first reason is the one that I mentioned earlier: the role of an old people's champion goes wider than health and social care. Equally importantly, the job of HealthWatch England will be to carry out functions in relation to people. The word "people" is a deliberately broad term and its ordinary meaning would include older people of course, so we do not feel that it would be appropriate to give a member of HealthWatch England a remit for older people, which would give additional weight to one group of people over another. It could also lead to calls for a commissioner for other groups like those with learning disabilities and it would be difficult to see where the list would stop.

Although I completely understand the concern that older people have often lacked a voice within the system, and the need to ensure that they are not overlooked, we do not agree that the singling out of this group over others, within the context of HealthWatch, would be the best way to achieve that. We want to address the concerns of the noble Baroness but not in this way. In the light of that and on the basis that she will continue to have discussions with my honourable friend on the issue in a wider sense, I hope that she will feel sufficiently reassured to withdraw her amendment.

Baroness Bakewell:

I thank the noble Earl for that engagement with the argument which I hope to start. Having a toe in the door, I hope that I can keep it open and perhaps prize it a little bit further open.

The noble Earl cites all the amazing institutions which are responsible for older people and one wonders why there is such a catalogue of misery across the country. Why are things going wrong? Why do they not answer the needs of older people? Why are there so many people catalogued as living wretched lives and writing letters of complaint, virtually with tear-stained ink? This is a major problem that the system is not answering. Therefore, I hope to take the issue further.

I very much agree with the noble Baroness, Lady Barker, that we should not medicalise the issue of being old. We have to keep old people fit so that they can enjoy old age. If this matter is to be referred to other government departments, I would include the DCMS so that access for older people to theatres and

cinemas, help with hearing and so on can improve their quality of life. There is much to be improved, as we all know. I welcome the noble Earl's commitment to making that so and I hope to follow it up in future. I beg leave to withdraw my amendment.

Amendment 231A withdrawn.

Clause 181 : Establishment and constitution

Amendment 231B

Moved by

Baroness Northover

231B: Clause 181, leave out Clause 181

Baroness Northover:

I shall speak also to the other government amendments in this group relating to local healthwatch. Local healthwatch goes to the heart of the Government's ambition for a health and care service that is centred around patients and users. In the consultation paper Liberating the NHS: Local Democratic Legitimacy in Health, published in July 2010, the Government stated:

"Local authorities have a vital role in commissioning HealthWatch arrangements that serve their local populations well … In the event of under-performance, a local authority should intervene; and ultimately re-tender the contract where that is in the best interests of its local population."

Local healthwatch will go further than just gathering views; it will be there to support individuals by providing information and advice about access to services and choice. We firmly believe that this will enable people to take more control of their own health, treatment and care, and understand and use the increased choices available to them. I am sure noble Lords will agree that this kind of support will be invaluable.

As a corporate body with a statutory function of carrying out statutory activities, local healthwatch will gather information about people's views and experiences of the health and social care system. This will enable the voice of people to reach commissioners and providers of health and social care services, a link that has been lacking in the past.

Local healthwatch will have a seat on every statutory health and well-being board which will prepare statutory joint strategic needs assessments and joint health and well-being strategies, which will inform local commissioning plans. Through local healthwatch the patient voice will influence and inform the work of the health and well-being board. I hope that noble Lords will agree that this will give local healthwatch much more influence at the decision-making table and will help hardwire public engagement into the strategic planning of health and care services from the start.

The evidence and insight gathered by local healthwatch will also inform HealthWatch England and enable it to advise on the national picture—for example, where it sees a pattern across a number of local concerns—which will ensure that local views will be able to influence national policy, advice and guidance.

This role will be strengthened following the amendments of the noble Baroness, Lady Tyler, which we accepted earlier when debating HealthWatch England.

We have always envisaged that local authorities, which will be responsible for commissioning local healthwatch, will have flexibility about its organisational form. This will enable them to take account of local needs and circumstances. We are pleased that senior voices within local government support the Government's policy intentions and are willing to use their leadership role to help support local authorities to drive effective commissioning and implementation at local level. This approach to local healthwatch aligns with the Government's localism agenda. However, on reflection we realised that greater flexibility was needed over the organisational form of local healthwatch, and for this reason we tabled the amendments in this group. We do not now think that prescribing from the centre that local healthwatch must be a statutory body corporate with an exact form is the best way forward.

Before listening to the views of noble Lords, perhaps I may address some concerns around the Government's approach to local healthwatches. The first relates to their status as statutory bodies with statutory functions. One issue that LINks have faced is the model itself. As they are inherently loose networks, they require a host to provide administrative and other support, which has caused difficulties in some areas. By establishing local healthwatch as a body corporate we will avoid the difficulties of this, as the local healthwatch will be able to employ staff as well as involving volunteers.

It is important that local healthwatch organisations will be corporate bodies with statutory functions setting out their powers and duties. We agree with the assertion of the National Association for Voluntary and Community Action that,

"a network of vibrant community led organisations, answerable to local people, will have far more bite than over 150 unaccountable quangos".

If we were to set out the more rigid requirements that statutory corporate bodies would have, this would be more likely to lend itself to the creation of such quangos.

Secondly, a number of noble Lords are concerned that there is a risk that a local authority will not wholeheartedly embrace entering into a contract with a body that will then criticise it. It is not new for local authorities to commission bodies, partly or fully, which then make their views known in feedback or reporting arrangements, with the net result of improving services locally. Examples include citizens advice bureaux, tenant organisations, legal advice centres and advocacy support. I assure noble Lords that these groups tend not to be afraid to come forward, and that most local authorities welcome such insight—as we heard yesterday from the LGA and others at the meeting to which noble Lords referred. It follows that there should be no problem were a local healthwatch organisation to share differing views or constructively criticise a local authority's commissioning or provision of care services. It will be useful for local authorities to hear that feedback.

The needs of local communities should play a part in who is contracted to become the local healthwatch. We want to ensure that the expertise that exists in the community has the opportunity to contribute to local healthwatch. For example, a local authority could commission a community interest company, charity or other form of social enterprise that meets the prescribed criteria. Local authorities will be best placed to make such decisions, based on their knowledge of their local area, and it will be right to allow each to commission a local healthwatch that is right for them.

Thirdly, a key failing of many LINks is their inability to involve a wide range of people and different sections of the community. We discussed this when debating the previous group of amendments. The result is that they lack diversity in their membership, which makes them unrepresentative of their local population. These issues are being addressed by healthwatch. There is a duty on healthwatch to be representative, in the sense of the population demographics of an individual local community, when carrying out its functions. In order for local healthwatch to be truly representative across the individual local community, the ambition is that it will be part of a system rooted in local experience, harnessing the expertise of the public, community and voluntary sectors and others at the local level, particularly those working with people and groups who have a difficult time getting their voices heard. I beg to move.

4.30 pm

Baroness Cumberlege:

My Lords, I have three amendments in this group. My Amendment 232, which is supported by my noble friend Lady Jolly, limits the role of the local authority vis-à-vis local healthwatch to just "pay and rations plus": that is to say, it makes sure that local healthwatch operates economically and efficiently, and develops work plans and delivers them, but does not interfere with what is in those work plans. This addresses local healthwatch independence and the local authority's accountability for respecting it. I see that the Government's policy document reflects this at paragraph 3.7, which states that local healthwatch will be,

"able to decide their own priorities and programmes of work, they will account to the local authority for their effectiveness and use of public funds. In turn, local authorities will be responsible for ensuring they are adequately funded and able to operate effectively".

That goes back to the point raised earlier by the noble Lord, Lord Harris, about funding.

After the concessions that have been made by the Government to my amendments, I am very reluctant to appear to be ungrateful or ungenerous, but I have to say that I am extremely concerned. I have had meetings with both my noble friends on this issue, but I am extremely concerned that as a result of new subsection (2B) proposed in government Amendment 235D—it puts lay people in, as I see it, a subsidiary foot-soldier role with no decision-making power—it is only paid staff in the local healthwatch social enterprise who will make decisions, for example, about criticising services in a local authority on which they depend for their employment. I fear that this wipes out the independence of local healthwatch from the local authority at a stroke. I am seeking assurances that the Government will think again on this as it undermines the whole plan and their intention to give local healthwatch the voice that it so badly needs.

My Amendment 237 provides a regulation-making power on how local authorities make their decisions about local healthwatch and, particularly, its funding. The Government's Amendments 226ZB to 226ZG help to address this by expanding the HealthWatch England role, especially by broadening its advice from specific to general in Amendment 226ZC and its new functions in Amendment 226ZG. This is very welcome, again providing we can have reassurances on Amendment 235D. At local level, my Amendment 236 puts beyond doubt that local healthwatch has statutory functions rather than mere activities, so that it can be clearly held to account for what it does by local people. I am very glad to see that the Government have addressed this in new subsection (2A) proposed by their Amendment 235D.

The accountability framework that I am seeking consists of local authorities influencing whether local healthwatch performs its functions, and I shall give three very quick examples. First, has representative membership taken place in local healthwatch and does it undertake enough work to make productive reports and recommendations? Secondly, are local people dictating what local healthwatch chooses to focus on when doing so? I am thinking of care homes, for example. Thirdly, does it work to the standard set by HealthWatch England? I am thinking of the quality of governance and the rigour of engagement. Local healthwatch needs to be able to get on with the job of giving local people influence on their local services as soon as possible with maximum support and minimum interference. Many of the latest amendments from the Government are a positive contribution to this objective, but there are new, very significant concerns, particularly about lay leadership, and I hope that the Government will address those issues today.

The greater their independence and transparency, the easier local healthwatch organisations will find it to recruit local people to their cause. We know that there are some highly motivated, very courageous and experienced members of Local Involvement Networks who have the knowledge, skills and relationships to give us value for money. This is particularly important at this time of transition. I agree with my noble friend Lady Northover that it is important to get over the administration process as soon as possible.

We know that there are people getting less than good care and treatment who need a voice, who need advocates to speak for them, advocates who are not treated as mere complainers but knowledgeable people who have real power and influence to improve health and social care. I hope that my noble friend will think about these issues.

Baroness Jolly:

My Lords, I was happy to add my name to Amendment 232, tabled by the noble Baroness, Lady Cumberlege, which puts in the Bill that it absolutely is the responsibility of the local authority to provide the finance for the local healthwatch to carry out its functions.

The local authority needs to develop confidence in its local healthwatch organisation—to see it as a partner, not a threat—enabling it to deliver not only its own services more effectively but those of its health partners. I hope that the Minister can indicate what might be the route to resolve any disputes about funding allocations to local healthwatch.

I will now talk about lay leadership on local healthwatch organisations. Lay leadership is absolutely critical to local healthwatch, and the noble Baroness, Lady Cumberlege, has outlined exactly why that is. It is a new PPI organisation and will need quickly to demonstrate integrity and independence to inspire local trust. The Government's own model for user-led organisations points the way and I commend it to the Minister. It calls for 75 per cent lay or user representation on the board. Will my noble friend confirm that any guidance the Government produce will give clarity on the composition of lay membership and the involvement of lay members in the day-to-day work of the local healthwatch and that the results of the government consultation exercise will be taken due note of?

Finally, I come to a definition contained within my Amendments 234 and 235. "Local care services" are defined in the Health and Social Care Act 2008 as both health and social care, but "local people" are not defined. This definition is to ensure that no one is omitted from the remit of local healthwatch. It encompasses people living in the council area covered by the local healthwatch, people receiving care in the area and people from the area who are receiving care elsewhere.

Local healthwatch organisations will be critical in the monitoring of the new patterns of health delivery called for within this Bill. They will be vital to ensure that standards do not fall in the time of austerity, and I wish them success.

Lord Harris of Haringey:

My Lords, this is a complicated group of amendments. There are, I think, 50 government amendments in this group that completely change the direction of this part of the Bill. Of course, we do not have the benefit of a Committee consideration of these changes, which is unfortunate, given the nature of the changes that are envisaged.

In fact, what we are being confronted with is an almost extraordinary volte-face by the Government about how local healthwatch organisations are going to operate and proceed. As it stood, before these amendments, the Bill provided local healthwatch with a very clear structure and very clear governance. It defined membership and it defined their role. As such, the arrangements were better than LINks, better than PPI forums and, in one or two respects, better than community health councils. It was a very clear statement. There remained the problem that local healthwatches were going to be the creatures of local government without the benefit of ring-fenced money and with the potential issues around conflicts of interest concerning social care. I am reminded that on 15 October 2007, the noble Earl, Lord Howe, clearly took the view that it was inappropriate for a local authority to be host to a LINk. Presumably, the same arguments that influenced his thinking then apply on this occasion.

We have been offered guidance on conflicts but, again, it is not clear how this will work, which is something that we could have pursued perhaps in detail in Committee. The amendment refers to having regard to the guidance on conflicts, which I suspect will not necessarily be strong enough for the sorts of conflicts of interest that potentially could arise. We also have the enormous concession, to which I referred earlier, of Amendment 226ZG, which enables HealthWatch England to write a letter if it feels that something has gone wrong.

That is where we were but now the Government, without explanation or consultation, have decided that local healthwatches will no longer be statutory bodies. We are told that that is all in the name of the need for flexibility. The noble Baroness has mentioned repeatedly the briefing which took place yesterday evening, to which, incidentally, I was not invited. Even had I been, I would not have been able to attend because the meeting clashed with the regular meeting of Labour Peers, which one would think that the Government would wish to avoid. At that meeting various papers were tabled which referred to the importance of flexibility but we are not clear as to what that flexibility will deliver.

In moving the amendment the noble Baroness talked about the Government's proposals in the Bill as creating a series of "unaccountable quangos". I recall previous briefings which I attended with Ministers and the Bill team when it was explained that there would be guidance about how the membership of local healthwatch was going to be derived and to demonstrate that these were going to be accountable bodies and not unaccountable quangos. Somewhere along the line, in the past few weeks, there has been this amazing change of attitude, which does not seem to follow the benefit of any real explanation or consultation with those who might take an interest in it.

That underpins the amendments spoken to by the noble Baronesses, Lady Cumberlege and Lady Jolly. The noble Baroness, Lady Cumberlege, highlighted the difficulty that would arise between members and staff. The noble Baroness, Lady Jolly, talked about the importance of lay leadership. In terms of the changes, the

Government are going to make it more difficult for there to be lay leadership and the role of members versus staff will be blurred still further. Indeed, the staff will be the dominant influence.

This is not a matter on which there has been consultation. I have received a note from the National Association of LINks Members, which states:

"Ministers say that they are 'not convinced' that LHW needs to be a stand-alone, statutory body corporate. It is not ministers who will be relying on LHW to get them a fair shake but the old, sick, vulnerable, frightened and marginalised and these, along with the rest of the patients and the public, are the ones who need to be 'convinced' that we have a model that will work".

It says that it is not convinced. It points out that local healthwatch should,

"have a standard 'platform' of presence everywhere in England, not merely through logos, straplines and brands"—

which the Government's amendments will make happen—

"but through a locally elected membership, a single 'address' and identifiable staff that it has appointed".

It says that only:

"Statutory, body corporate status would deliver this".

It continues:

"Government says it does not want a top-down model but it is making top-down decisions, and these fly in the face of all the evidence of the past three and a half years of LINks, all the advice of all the LINks' members of the government's own HealthWatch Advisory Board, of the National Association of LINks Members, all the advice of many, many LINks all over England. 'Being heard' has simply vanished from the national scene. The government pontificates on what it does not practise. It legislates but it does not listen".

It suggests, although I could not possibly automatically agree, that:

"What the Government actually fears is 152 statutory LHWs, with genuine independence, with real clout and public buy-in, a separate identity, and powerful and committed membership".

If that is the concern, where do we go from here? I am taken with the sage advice your Lordships received from the noble Earl, Lord Howe, when we debated the creation of LINks, the slightly ill-fated proposal by the previous Labour Government. The noble Earl, in his typically courteous but forceful way, said then—given these government amendments, you can simply substitute HealthWatch for LINks:

"We have come to a group of amendments most of which in their different ways relate to the same problem. I use the word 'problem' as the most neutral term I can readily think of for what many of us regard as a most serious and regrettable weakness in this part of the Bill; namely, the absence of even the

slightest hint of a statutory identity for LINks. There is a complete lack of any descriptive reference to what a LINk might look like and practically no definition of a LINk".

That was the noble Earl, Lord Howe, talking about the creation of LINks. Yet today he has brought forward amendments—admittedly he has delegated this to the noble Baroness, Lady Northover, who is acting as his mouthpiece on this occasion—that will do precisely what he complained that the previous Government did.

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course he said much more than that. I will not burden the House by repeating all the remarks he made in October 2007, but if we substitute HealthWatch for LINks every time it appears, we will get the flavour. He went on to say:

"As the Bill stands there are no provisions for LINks to have any form of governance arrangements; it is left completely open as to how a LINk would be able to make decisions or authorise people to act on its behalf. This is a major issue because without some form of governance you cannot have accountability. If there are no people authorised to act on its behalf, a LINk cannot be accountable".—[Official Report, 15/10/07; col. 567.]

He later said:

"The key issues around governance are really three: how decisions are to be made; how activities are to be undertaken; and, who is to do these things? Without those minimum requirements we would be left with a situation where someone who has joined a LINk, but who never attended any meetings or received any training or signed any code of conduct",—[Official Report, 15/10/07; col. 568.]

could proceed in particular ways. So the lack of statutory identity was something that the noble Earl, Lord Howe, told this House was absolutely critical when we debated the creation of LINks. And he was absolutely right. I remember agreeing with him at the time and feeling that my Government had got it wrong. But this is the point. The Government have now brought forward amendments which undo all his fine words at that time and all his attempts to put this right, and that is because statutory status at the local level was what was going to give HealthWatch a cutting edge, an authority in terms of its relationships with other bodies.

The noble Earl also had a few words to say about the underlying argument that this should be delegated down. He said then, and we could say it to him now, that we were told that the Government did not want to be "prescriptive" and that it would be up to each LINk to set itself up in the way it wanted.

In June 2007, he quoted a telling Greek legend. Indeed, he may remember using this example:

"I think it was Proteus who was able to assume any shape or form that he liked. The reason why he did this was in order to avoid foretelling the future. For us debating this part of the Bill, it is almost impossible to foretell the future because neither the governance arrangements of LINks, nor their structures, nor their powers, nor even the precise scope of their activities, are set out here. In a real sense, as with Proteus, we do not know who or what we are dealing with".

With these amendments before us today, the Government are substituting something else when we would have known what we were dealing with and where there were precise governance arrangements. But they are taking all that away and moving towards something that the noble Earl also, presciently, described in that debate, saying:

"As I understand it—the Minister may correct me—because LINks are not defined they are not classifiable as statutory bodies. We may know a LINk when we see it—although I am not completely sure about that—by virtue of the things that it does … The Bill refers to activities being 'carried on'".

I look at these amendments and, my goodness, Amendment 236C in the name of the noble Earl talks about,

"activities carried on for the benefits of the community in England".

Incidentally, how a local organisation is supposed to act in the benefits of "the community in England" seems to be a very odd use of words. However, phrases such as "activities carried on" were precisely what he said then was the wrong way of going on.

The noble Earl went on to say in that June 2007 debate:

"In fact, in one way or another, there is quite a lot of carrying on in this part of the Bill. There may be a joke there somewhere but I shall refrain from trying to find it. But that nebulous form of drafting is as far as we get. It will be incumbent on us in Committee"—

we do not have the benefit of being in Committee today—to sort out this unsatisfactory regime. He continued:

"The main problem with the Bill is that because LINks"—

and you could say the same about HealthWatch now—

"have no identity or definition, they can be seen neither as bodies whose independence is guaranteed, nor as bodies which have the power to hold local health and social care commissions to account".—[Official Report, 20/6/07; cols. 252-3.]

Those were the wise words of the noble Earl, Lord Howe, then, but he is the same noble Earl who is bringing forward amendments that create the same precisely the structure that he said was totally inappropriate then.

Let us look at what the Government are doing and I will be brief. Amendment 231B removes the statutory status. Amendment 231C removes all structure, form and governance from the Bill. Amendment 234A talks about "one set of arrangements". It implies not just a single arrangement in any local authority area, but a set of arrangements, so it would not necessarily be one contractual arrangement: it would be a set of contractual arrangements. The word "arrangement" is in the plural.

Amendment 235C is the great catchall that tells us it is all going to be all right and that all these bodies are going to be the same in that there will be a licence to use a trademark. I am enormously reassured by that. Amendment 235D provides for subcontractors for the different functions. So what we are envisaging

is that a local authority will divide up the functions of HealthWatch organisations and contract each of them to a separate organisation. Does that really make sense? Is that the strong patient voice that we were promised at local level?

In Amendments 238ZM and 238ZN there are specific references to contractors. This is essentially moving from a position where there will be a clear number of local statutory bodies delivering patient representation on behalf of their communities, with members from those communities running those organisations, because that is what the governance arrangements were before. This is essentially privatising that process, albeit by so-called social enterprises. This is privatising consumer representation.

How can contractors be representative? Yes, there is an amendment that says that these contractors will be broadly representative of the local community, but how can an enterprise itself be representative of the local community? I find this concept difficult to understand. Because we are not in Committee, we do not have the opportunity to have it explained to us fully and a chance to probe the Government.

The amendments that we talked about a few minutes ago envisaged that local healthwatch would be able to have local representation on the board of HealthWatch England. How will we have representatives from local healthwatch organisations—the arrangements that will be subcontracted for different functions to social enterprises—how will representatives be produced at the national level for HealthWatch England? Is this going to be board members of a social enterprise, charged with the effective running of that enterprise not the representation of the community? Will it be the staff? That comes back to the point about lay leadership that the noble Baroness, Lady Jolly, raised earlier.

Last night, I got an e-mail from an existing LINk member, with whom I have never previously communicated, saying:

"I'm much involved with my local LINk, which it can be argued, has already been 'taken over' by its Host in advance of the Privatisation of the Public's voice when HealthWatch comes about. Lay 'Volunteers' have been demoted from being Members to Participants"—

there is the lay leadership of the noble Baroness, Lady Jolly—

"and our Management Committee has been redesignated as an 'Advisory Group'"—

again, lay leadership—

"with few if any powers over anything. Expulsions have been initiated against those who don't toe the new autocratic line—and the local authority just turns a blind eye despite appeals to the Council Leader, CEO and Portfolio holder. What hopes for a voice for the public/patient when Local Healthwatch is in place?".

I believe that the Minister received a letter from another member of a local LINk who talks about his dedicated service. He lists at some length all the different bodies that he has sat on representing the public, then says that,

"My most precious resource—the time I have given—has, at a stroke, been set to nought".

There is no local lay leadership in these arrangements. That is why these amendments are so sad.

We have to ask why the Government are doing this. Is it because some unit in the Cabinet Office has suddenly discovered this bit of the Health and Social Care Bill and said, "Oh, they have missed something out about the opportunity to introduce competition so let us put it in this bit of the Bill"? Or perhaps it is because Government Ministers have suddenly realised that the Bill is rather unpopular. There are some difficulties with it, the public's perceptions of it are increasingly negative, so having proper patient representation would now be extremely dangerous.

Lord Trefgarne:

My Lords, the noble Lord has been going on for a considerable period in connection with the government amendment. He now speaks about the Bill in general. That is really a Second Reading issue. This is Report. Could he indicate how much longer he intends to be?

Lord Harris of Haringey:

Actually, I had finished my last sentence when the noble Lord stood up. I raised that because the question arises as to why the Government have introduced these amendments. Given the attitude to the whole Bill, one has to question their motivations. I hope that when the noble Baroness eventually—I assume—gives us her usual, extremely full exposition, she will explain precisely the motivation for this change, so as to indicate that the fears being expressed are totally misplaced.

Lord Low of Dalston:

My Lords, I will be briefer than but have a good deal of sympathy with the noble Lord, Lord Harris, who has just spoken. It seems that the consumer's voice in the health service has been progressively watered down since the days of community health councils—almost to the point of extinction in the legislation before us. As is clear from the debate, there are many concerns over the question of independence, nowhere more than in relation to the proposed structure in which, as I understand it, there is no longer to be a distinct healthwatch organisation. Rather, local authorities will be able to put the local healthwatch functions out to tender on a piecemeal basis.

I apologise to noble Lords but my technology is playing up a bit today. Concerns have particularly focused on the threat to independence which might arise from the possibility that, in the current climate, local authorities will seek to retain some of the healthwatch funding for other purposes, given that it is not ring-fenced. The proposed funding regime is the same that obtains for LINks—that is, from central government via the local authority. We can perhaps gain some idea of the credibility of the concern by considering what has happened in relation to LINks funding.

In a study of LINks funding for the current financial year, the National Association of LINks Members revealed that most LINks had their funding cut. An informant from my local LINk told me that after discussion that he has had with other LINks it would appear that a number of local authorities will keep the funding of LINks for 2012-13 at the same level as for the present year. The effect is that while the Department of Health may have increased the funding of LINks to allow for inflation, that is not being passed on. He says that in respect of his own LINk in Hackney, in 2010-11 it received £206,000, which represented the whole amount of the funding provided by the Department of Health. In 2011-12, only £100,000 was provided, and the same amount will be provided for 2012-13.

In relation to the argument that local authorities may retain some of the funding for HealthWatch, the Government argue that local authorities will be under a statutory duty to fund HealthWatch. That may be true, but local authorities are currently under a similar duty in relation to LINks and that has not stopped them cutting LINks budgets. For that reason, as well as for conflict of interest and status reasons, HealthWatch needs to be a consolidated, coherent and independent body with standing—or at least, as a minimum, to have a ring-fenced budget.

Baroness Wheeler:

My Lords, on behalf of these Benches, I want to express our concern and exasperation at these cobbled-together last-minute changes to the status and organisational arrangements for local healthwatch. We are utterly opposed to depriving local healthwatch of its statutory status. It is hard to see the logic behind the new approach, even for those of us who are supportive of the local development of social enterprises.

The noble Baroness has not explained why this last-minute change is taking place 14 months into the consideration of the Bill. Why was this new approach and dramatic change not spelt out and included in the consultation that the Government have conducted since Committee stage on HealthWatch membership? Why such a fundamental change of direction at this late stage?

The Government's argument is that the new arrangements will provide local authorities with the flexibility that they need in establishing HealthWatch organisations and facilitating their networking with other local community organisations. In practice, this means that not only will each local healthwatch be very different, and it will take more than the proposed national kite mark to provide them with any joined-up coherence, but they will all develop at a very different pace as local authorities take time to decide on the form of structure, and then draw up and implement their commissioning arrangements, or further subcontracting arrangements, if they want to make things really confusing, and so on. This is hardly the smooth transition from LINks organisations to the proper and coherent structure of patient representation at local level that we need. Like so much in this Bill, what could be simple and straightforward is made fragmented and complicated and requires detailed explanation. The Government also make strong play of local healthwatch organisations having a statutory function through a seat on health and well-being boards, through making a contribution on that board and the statutory joint strategic needs assessments and the joint health and well-being strategy. HealthWatch will also have statutory status through the statutory health and well-being boards' ability to refer back to the NHS Commissioning Board plans that do not meet the needs of the local communities. So we have a second-hand, reflected statutory authority by participating in bodies that have statutory status.

It is interesting, too, that with clinical commissioning groups the Government have repeatedly argued that the Bill was needed to enable CCGs to be statutory bodies in their own right. Now we see exactly the opposite argument when it comes to patient representation.

Finally, there is the relationship of local healthwatch with the local authority, where there is again huge potential for conflict of interest, and concern that even the well intentioned authorities facing severe budget cuts could struggle to find the required funding for healthwatch organisations. Government amendments to address this and potential conflicts of interest by requiring local authorities to,

"have regard to ... any Secretary of State guidance on this matter",

do not provide the safeguards that would be needed to ensure that patients, their carers or representatives should be able to expect if they are concerned that their complaint about a social services department is channelled through a non-statutory body funded and linked to the local authority itself.

As with the rest of the Bill, these are complicated structures understood and supported by no one, with details fleshed out at the last minute and sprung upon the House, in effect, only three working days before we are due to consider them, and with no opportunity for consultation on such fundamental change. Arguably most important of all is that it is impossible to see, among all these amendments, how these local organisations will relate to national HealthWatch. Perhaps the kite marks are designed more to help HealthWatch England recognise who it has under its umbrellas than to assist local organisations networking with each other.

I hope that even at this late stage the Minister will acknowledge the concern, confusion and demoralisation, particularly among key patient organisations and groups, at the last-minute decision to change the status of local healthwatch organisations. I hope that she will agree to withdraw these amendments and instead restore statutory status to local healthwatch, enabling them to be organisations that everyone can rely on to be genuine patient representatives, fully trusted and supported by patients and the public.

Baroness Northover:

Again, my Lords, what shines through is a great commitment to public and patient involvement at a local level; the only dispute is over the form of that. Again, noble Lords are familiar with the fact that various models have been tried, and I emphasise once again that we are seeking to build on the strengths of what has worked and mitigate some of the problems that have been encountered.

My noble friend Lady Jolly has tabled Amendments 234 and 235, the result of which would be to replace references to "people" with "local people" in Section 221 of the 2007 Act and insert the definition of "local people". We talked about the difficulty of organisations—LINks in particular—reaching groups that were defined as hard to reach. The definition in my noble friend's amendment says that when carrying out its functions, local healthwatch has to be representative of people who live in the area, service users and people who are representative of the local community. That applies to people of all ages and emphasises the need for local healthwatch to champion the views of the whole breadth of the local community. I am therefore grateful to my noble friend for this contribution, and I am happy to support her amendments.

Although I am sympathetic to the sentiment behind my noble friend Lady Cumberlege's Amendments 232, 236 and 237, I hope I can reassure noble Lords that, as corporate bodies, local healthwatches will have the flexibilities to make their own arrangements for securing staff, accommodation and so on, so the local authority should not have to make such arrangements on their behalf. There is no need for express provision on payment of expenditure because the legislation requires local authorities to make arrangements to ensure that the relevant activities can be carried on in their area. Necessarily, that means providing adequate funding to enable the functions to be carried out. This is an important point that I hope reassures noble Lords: the statutory functions must be delivered, and that is a protection of these bodies.

My noble friend Lady Cumberlege is quite right about local healthwatches working out their own priorities and work, and they will no doubt be doing that in conjunction with what is found to be good practice around the country, information coming from HealthWatch England and so on. I assure my noble friend

that staff are there to help to facilitate such work, not to dominate it. My noble friend Lady Jolly is right: local healthwatch is a partner with local authorities—the eyes and ears, as the noble Baroness, Lady Murphy, and others have said.

My noble friend Lady Cumberlege was concerned that government amendments would damage local healthwatch's independence. I do not agree: the amendments do not dilute in any way the statutory functions of local healthwatch, including the ability to give advice to local authorities among others. In response to concerns that local authorities may try to suppress local healthwatch, we specifically brought forward Amendment 236E giving the Secretary of State the ability to publish conflicts of interest guidance that both local authorities and local healthwatch would have to have regard to.

The noble Lord, Lord Harris, raised a number of issues. He regretted the fact that yesterday he was not at the seminar that I mentioned. I regret that he was not there. It was interrupted by a couple of votes, but I am sure that he would have engaged with those who were speaking there. That would have helped to inform everybody. All Peers were invited and some from his group attended. I see a few shaking heads.

Lord Hunt of Kings Heath:

My Lords, the seminar was held during the regular meeting of Labour Peers which has occurred at 5 pm on Wednesday evenings since time began.

Baroness Northover:

I am very sorry if there was a conflict of timing. Obviously it is difficult to schedule all the various meetings. My noble friend Lord Howe has had 100 meetings on this Bill.

Baroness Thornton:

This has happened all the way through.

Baroness Northover:

I am very sorry if that was the case. If it was the case all the way through, as the noble Baroness, Lady Thornton, indicates, perhaps it might have been an idea to feed that in.

Baroness Thornton:

The noble Baroness might like to check with the Box. I informed the noble Earl's office of the times of our group meetings at the beginning of proceedings. Meetings and seminars have clashed all the way through.

Baroness Northover:

I am very sorry if that is the case. I would hope that we would be able to have other such meetings. As these arrangements are taken forward, it would be extremely useful to have people's engagement. I was extremely glad that, even in such a clash, the noble Baroness, Lady Wheeler, and her noble friend were there.

The noble Lord, Lord Harris, should have received the letter about the amendments, but I gather that he thought he had not. A letter and briefing notes were sent to all Peers when the amendments were tabled and a full narrative of local healthwatch policy has been published on the Department of Health website. If the noble Lord has not seen the letter then I will feed that into the department to make sure that he receives this information so that he has it at his fingertips when he is contacted late at night by people who email him with concerns.

As I have mentioned before, it is very important that the local healthwatch seeks out views right across the area. It is an important factor in this arrangement that the local healthwatch will have a seat on the health and well-being board. I hope that that will help to reassure people of the influence of local healthwatch.

The noble Lord, Lord Harris, talked about privatisation by so-called social enterprises, or he flagged that up as a concern. I emphasise that the Government are huge fans of social enterprises, which perform a range of roles across the NHS. Social enterprises such as Turning Point are, of course, extremely valuable. This is not about privatisation or competition, as I feel we have made very clear.

The noble Lord, Lord Harris, also referred to my noble friend Lord Howe. My noble friend's concern in 2007 was that local LINks should have at least a basic structure of governance. That is precisely the concern that has led us to propose that local healthwatches should be social enterprises. The question of governance is quite separate from the question of whether or not an organisation should be statutory. Perhaps the noble Lord, Lord Harris, can enter dialogue with my noble friend Lord Howe on all of that in due course.

The noble Lord, Lord Harris, also asked about the possibility of there being more than one local healthwatch. Only one local healthwatch will be permitted for each local authority area. Each local authority will be able to make only one contract. If the local healthwatch wishes to subcontract some of its functions it can do so if the local authority permits, but the functions would still remain the responsibility of the local healthwatch. I hope that that clarifies the position.

5.15 pm

Lord Harris of Haringey:

I was trying to establish whether it would be possible, under these amendments, to segment the various functions of local healthwatch and contract them separately. I think the noble Baroness has just confirmed that. Am I right?

Baroness Northover:

The key fact is that there is one local healthwatch for any local authority area. If it decides that it wants to subcontract something to best achieve what it needs, that is up to that local healthwatch. The noble Lord might want to bear in mind the statutory functions of local healthwatch and its responsibilities as eyes and ears. If it was not working, I am sure that noble Lords such as he would flag that up. Local healthwatch would then have to justify what it was doing and might need to move away from it.

I realise that time is pressing and it is a Thursday afternoon. I have listened to the concerns expressed about the need for local healthwatch to have strong lay involvement. I completely agree. This will be vital to the success of local healthwatch. Therefore, I confirm to the House today that we will use the power of

the Secretary of State to specify criteria, which local healthwatch must satisfy, to include strong involvement by volunteers and lay members, including in its governance and leadership. This will have the effect that a local authority cannot award a local healthwatch contract to a social enterprise unless this condition is satisfied. I hope that that provides reassurance to noble Lords. My noble friend Lady Jolly also flagged this up.

The noble Lord, Lord Low, the noble Baroness, Lady Wheeler, and others raised the issue of funding for local healthwatch. It is important that local authorities can manage local priorities, since they are best placed to respond to their local communities. Therefore, local healthwatch will remain within local authority funding mechanisms, as I mentioned earlier. This view was supported by the NHS Future Forum, which made clear in its Patient Involvement and Public Accountability report that it did,

"not agree that budgets for local Healthwatch should be ring fenced".

However, to reassure noble Lords, I point out that statutory functions must be delivered. This helps to protect what local healthwatch is there to do.

I believe that there is consensus over our ambition for local healthwatch. We do not disagree about what we want it to do for people or to accomplish in order to raise the quality of care. I hope that I have reassured noble Lords that it is right for local healthwatch to be delivered at a local level by organisations that are accountable locally. To embed healthwatch in localism will not only enable the organisational form of local healthwatch to best meet the needs of the local population but better enable local healthwatch to play an effective role in feeding back people's views and promoting their involvement in the scrutiny and provision of local care services. I refer again to the positive reaction of several different local authorities and councillors who are very pleased that they will now be involved in many elements of the healthcare services, as they are in public health.

Lord Harris of Haringey:

Could the noble Baroness tell us how many LINks have been in touch with the department to say that they welcome these changes?

Baroness Northover:

Like the noble Lord, I recognise that the organisations which are in place when change occurs are always concerned. LINks have rightly expressed concern about whether what they know works well in what they do will be taken forward. They are very open about the challenges that they faced and some of the areas in which they have not done as well as intended. I pay tribute to the then Government for trying to make the system work when it was set up. It was a reaction to what had been done before and a looser model. Everybody in the system wanted that to work as a model. However, I think that the noble Lord has admitted that it has not worked universally. It is therefore understandable that the relevant organisations expressed concerns. I hope that they will become involved in the new system and that what they have contributed—the volunteers among them have made an effective contribution in many areas—will feed into local healthwatch. With that, I hope that noble Lords will accept the Government's amendments.

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Amendment 231B agreed.

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- Tugendhat, L.
- Tyler, L.
- Verma, B.
- Wakefield, Bp.
- Wallace of Saltaire, L.
- Wallace of Tankerness, L.
- Walmsley, B.
- Wasserman, L.
- Waverley, V.
- Wei, L.
- Wheatcroft, B.
- Wilcox, B.
- Williams of Crosby, B.
- Willis of Knaresborough, L.
- York, Abp.
- Younger of Leckie, V.

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- Anderson of Swansea, L.
- Andrews, B.
- Bach, L.
- Bakewell, B.
- Bassam of Brighton, L. [Teller]
- Beecham, L.
- Berkeley, L.
- Blackstone, B.
- Borrie, L.
- Boyd of Duncansby, L.
- Bragg, L.
- Browne of Ladyton, L.
- Clancarty, E.
- Clinton-Davis, L.
- Cohen of Pimlico, B.

- Collins of Highbury, L.
- Condon, L.
- Crisp, L.
- Davies of Oldham, L.
- Dean of Thornton-le-Fylde, B.
- Donaghy, B.
- Donoughue, L.
- Drake, B.
- Dubs, L.
- Emerton, B.
- Finlay of Llandaff, B.
- Gale, B.
- Gilbert, L.
- Glasman, L.
- Gould of Potternewton, B.
- Grantchester, L.
- Grenfell, L.
- Hannay of Chiswick, L.
- Harries of Pentregarth, L.
- Harris of Haringey, L.
- Harrison, L.
- Hart of Chilton, L.
- Haskel, L.
- Haworth, L.
- Hayter of Kentish Town, B.
- Healy of Primrose Hill, B.
- Henig, B.
- Howarth of Newport, L.
- Howells of St Davids, B.
- Hunt of Kings Heath, L.
- Jay of Paddington, B.
- Kennedy of Southwark, L.
- Layard, L.
- Lea of Crondall, L.
- Liddle, L.
- Lipsey, L.
- Low of Dalston, L.
- McAvoy, L.
- McDonagh, B.
- MacKenzie of Culkein, L.
- McKenzie of Luton, L.
- Masham of Ilton, B.
- Massey of Darwen, B.
- Meacher, B.
- Morgan of Drefelin, B.
- Morris of Aberavon, L.
- Owen, L.
- Ponsonby of Shulbrede, L.

- Prescott, L.
- Quin, B.
- Ramsay of Cartvale, B.
- Rea, L.
- Rosser, L.
- Royall of Blaisdon, B.
- Sawyer, L.
- Scotland of Asthal, B.
- Sherlock, B.
- Simon, V.
- Singh of Wimbledon, L.
- Smith of Basildon, B.
- Smith of Finsbury, L.
- Stevenson of Balmacara, L.
- Stone of Blackheath, L.
- Temple-Morris, L.
- Thornton, B.
- Tomlinson, L.
- Tunnicliffe, L. [Teller]
- Turnberg, L.
- Turner of Camden, B.
- Wall of New Barnet, B.
- Watson of Invergowrie, L.
- Wheeler, B.
- Whitaker, B.
- Whitty, L.
- Williams of Elvel, L.
- Young of Norwood Green, L.

5.31 pm

Schedule 15: Local Healthwatch organisations

Amendment 231C

Moved by

Earl Howe

231C: Schedule 15, leave out Schedule 15

Amendment 231C agreed.

Clause 182: Activities relating to local care services

Amendments 232 and 233 not moved.

Amendment 234

Moved by

Baroness Jolly

234: Clause 182, page 180, line 15, after "(2)" insert "—

(a) in each of paragraphs (a) to (c), before "people" insert "local", and

(b) "

Amendment 234 agreed.

Amendment 234ZA

Moved by

Baroness Tyler of Enfield

234ZA: Clause 182, page 180, line 28, after "Commission);" insert—

"(ga) making recommendations to that committee to publish reports under section 45B(3) of the Health and Social Care Act 2008 about particular matters;"

Amendment 234ZA agreed.

Amendment 234A

Moved by

Earl Howe

234A: Clause 182, page 180, line 37, at end insert—

"( ) After subsection (3A) insert—

"(3B) Each local authority must ensure that only one set of arrangements under subsection (1) in relation to its area is in force at any one time.""

Amendment 234A agreed.

Amendment 235

Moved by

Baroness Jolly

235: Clause 182, page 180, line 37, at end insert—

"( ) In subsection (6), after the definition of "local care services" insert—

""local people", in relation to a local authority, means—

(a) people who live in the local authority's area,

(b) people to whom care services are being or may be provided in that area,

(c) people from that area to whom care services are being provided in any place, and

(d) people who are (taken together) representative of the people mentioned in paragraphs (a) to (c);"."

Amendment 235 agreed.

Amendments 235A to 235C

Moved by

Earl Howe

235A: Clause 182, page 180, line 38, leave out subsection (7) and insert—

"(7) In the title to section 221, omit ": local involvement networks"

235B: Clause 182, page 180, line 39, at end insert—

"( ) For the cross-heading preceding that section substitute "Local arrangements"."

235C: Clause 182, page 180, line 39, at end insert—

"( ) After section 45B of the Health and Social Care Act 2008 (inserted by section 180(4)), insert—

"45C Granting licence to use trade mark

(1) The Commission may grant a Local Healthwatch organisation a licence authorising the use, in relation to the carrying on of activities under arrangements made under section 221(1) of the Local Government and Public Involvement in Health Act 2007, of a registered trade mark of which the Commission is the proprietor.

(2) A licence under this section may not provide for the grant of a sub-licence by the licensee other than a sub-licence authorising the use of the mark by a Local Healthwatch contractor in relation to the carrying on of Local Healthwatch arrangements.

(3) In this section—

"Local Healthwatch arrangements" has the meaning given by section 222 of the Local Government and Public Involvement in Health Act 2007,

"Local Healthwatch contractor" has the meaning given by section 223 of that Act, and

"registered trade mark" and "use" have the same meaning as in the Trade Marks Act 1994.""

Amendments 235A to 235C agreed.

Clause 183: Local authority arrangements

Amendment 235D

Moved by

Earl Howe

235D: Clause 183, page 181, leave out lines 2 to 4 and insert—

"(2) The arrangements must be made with a body corporate which—

(a) is a social enterprise, and

(b) satisfies such criteria as may be prescribed by regulations made by the Secretary of State.

(2A) For so long as the arrangements are in force, the body with which they are made—

(a) has the function of carrying on in A's area the activities specified in section 221(2), and

(b) is to be known as the "Local Healthwatch organisation" for A's area.

(2B) But the arrangements may authorise the Local Healthwatch organisation to make, in pursuance of those arrangements, arrangements ("Local Healthwatch arrangements") with a person (other than A) for that person—

(a) to assist the organisation in carrying on in A's area some or all of the activities, or

(b) (subject to provision made under section 223(2)(e)) to carry on in A's area some (but not all) of the activities on the organisation's behalf."

Amendment 235D agreed.

Amendment 236 not moved.

Amendments 236A to 236F

Moved by

Earl Howe

236A: Clause 183, page 181, line 5, leave out subsection (3) and insert—

"(3) In subsection (3), for the words from the beginning to "who is not" substitute "None of the following is capable of being a Local Healthwatch organisation"."

236B: Clause 183, page 181, line 7, leave out subsection (4) and insert—

"(4) For subsection (4) substitute—

"(4) The arrangements must secure the result that Local Healthwatch arrangements will not be made with a body of a description specified in subsection (3) or with the National Health Service Commissioning Board.""

236C: Clause 183, page 181, line 19, leave out subsection (7) and insert—

"(7) For subsection (8) substitute—

"(8) For the purposes of this section, a body is a social enterprise if—

(a) a person might reasonably consider that it acts for the benefit of the community in England, and

(b) it satisfies such criteria as may be prescribed by regulations made by the Secretary of State.

(9) Regulations made by the Secretary of State may provide that activities of a prescribed description are to be treated as being, or as not being, activities which a person might reasonably consider to be activities carried on for the benefit of the community in England.

(10) In subsections (8) and (9), "community" includes a section of the community; and regulations made by the Secretary of State may make provision about what does, does not or may constitute a section of the community.""

236D: Clause 183, page 181, line 19, at end insert—

"( ) For the title to section 222 substitute "Local Healthwatch organisations"."

236E: Clause 183, page 181, line 19, at end insert—

"( ) After section 222 insert—

"222A Local authority arrangements: conflicts of interest

(1) In making arrangements under section 221(1), a local authority must have regard to any conflicts guidance issued by the Secretary of State.

(2) Arrangements under section 221(1) must require the Local Healthwatch organisation, in exercising its function of carrying on the activities specified in section 221(2) or in making Local Healthwatch arrangements, to have regard to any conflicts guidance issued by the Secretary of State.

(3) In this section, "conflicts guidance" means guidance about managing conflicts between—

(a) the making of arrangements under section 221(1), and

(b) the carrying-on of the activities specified in section 221(2).

(4) In this section, "Local Healthwatch arrangements" has the meaning given by section 222."

236F: Clause 183, page 181, line 20, leave out subsections (8) to (11)

Amendments 236A to 236F agreed.

Amendment 237 not moved.

Amendment 237A

Moved by

Earl Howe

237A: After Clause 183, insert the following new Clause—

"Local arrangements: power to make further provision

(1) Section 223 (power to make further provision about local authority arrangements) is amended as follows.

(2) In subsection (1), for "require prescribed provision to be included in local involvement network arrangements" substitute "include prescribed provision".

(3) After that subsection insert—

"(1A) The Secretary of State may make regulations which provide that local authority arrangements must require Local Healthwatch arrangements to include prescribed provision."

(4) In subsection (2)—

(a) for "must require local involvement network arrangements to include" substitute "must include or (as the case may be) must require Local Healthwatch arrangements to include",

(b) in paragraphs (a), (c) and (d), for "a local involvement network" substitute "a Local Healthwatch organisation or a Local Healthwatch contractor", and

(c) after paragraph (d) insert ";

(e) prescribed provision relating to the activities which a Local Healthwatch contractor may not carry on on a Local Healthwatch organisation's behalf;

(f) prescribed provision relating to the obtaining by a Local Healthwatch organisation of a licence under section 45C of the Health and Social Care Act 2008 and the grant by the organisation to a Local Healthwatch contractor of a sub-licence;

(g) prescribed provision relating to the use by a Local Healthwatch organisation or a Local Healthwatch contractor of the trade mark to which a licence under that section relates;

(h) prescribed provision relating to the infringement of the trade mark to which a licence under that section relates;

(i) prescribed provision relating to the imposition of a requirement on a Local Healthwatch organisation to act with a view to securing that its Local Healthwatch contractors (taken together) are representative of—

(i) people who live in the local authority's area,

(ii) people to whom care services are being or may be provided in that area, and

(iii) people from that area to whom care services are being provided in any place."

(5) After subsection (2) insert—

"(2A) The provision which may be prescribed in relation to a Local Healthwatch contractor includes provision that relates to the contractor—

(a) only in so far as it assists the Local Healthwatch organisation in the carrying on of activities specified in section 221(2);

(b) only in so far as it carries on such activities on the organisation's behalf.

(2B) Regulations under this section may make provision which applies to all descriptions of Local Healthwatch contractor, which applies to all those descriptions subject to specified exceptions or which applies only to such of those descriptions as are prescribed."

(6) In subsection (3)—

(a) before the definition of "a local involvement network" insert—

""care services" has the meaning given by section 221;",

(b) omit the definition of "a local involvement network",

(c) for the definition of "local involvement network arrangements" substitute—

""Local Healthwatch arrangements" has the meaning given by section 222;"

(d) after that definition insert—

""Local Healthwatch contractor", in relation to a Local Healthwatch organisation, means a person with whom the organisation makes Local Healthwatch arrangements;", and

(e) after the definition of "prescribed provision" insert ";

"trade mark", and "use" and "infringement" in relation to a trade mark, each have the same meaning as in the Trade Marks Act 1994.""

Amendment 237A agreed.

Clause 184 : Independent advocacy services

Amendment 238 not moved.

Amendments 238ZA to 238ZF

Moved by

Earl Howe

238ZA: Clause 184, page 182, line 14, at end insert—

"( ) a complaint under section 73C(1) of the National Health Service Act 2006;

( ) a complaint to a Local Commissioner under Part 3 of the Local Government Act 1974 about a matter which could be the subject of a complaint under section 73C(1) of the National Health Service Act 2006; or"

238ZB: Clause 184, page 182, line 29, leave out subsection (5)

238ZC: Clause 184, page 182, line 36, leave out "or" and insert "the arrangements or arrangements made"

238ZD: Clause 184, page 182, line 41, leave out from "to" to end of line 44 and insert—

"(a) a person providing services under arrangements under this section;

(b) a person arranging for the provision of services in pursuance of arrangements under this section;

(c) a person providing services under arrangements made in pursuance of arrangements under this section."

238ZE: Clause 184, page 182, line 45, leave out subsection (8)

238ZF: Clause 184, page 183, line 2, leave out "or in pursuance of arrangements under this section" and insert "arrangements under this section or arrangements made in pursuance of the arrangements"

Amendments 238ZA to 238ZF agreed.

Clause 185: Requests, rights of entry and referrals

Amendments 238ZG to 238ZV

Moved by

Earl Howe

238ZG: Clause 185, page 183, line 42, after "organisation" insert "or a Local Healthwatch contractor"

238ZH: Clause 185, page 184, line 1, leave out "or in pursuance of"

238ZJ: Clause 185, page 184, leave out lines 4 and 5 and insert—

"(b) in compliance with a requirement imposed by virtue of section 223(2)(i)."

238ZK: Clause 185, page 184, line 5, at end insert—

"(3A) For the purposes of subsection (1), something is done by a Local Healthwatch contractor if it is done by that contractor in the carrying-on, under Local Healthwatch arrangements, of activities specified in section 221(2)."

238ZL: Clause 185, page 184, line 5, at end insert—

"( ) After subsection (4) insert—

"(5) In this section—

"Local Healthwatch arrangements" has the meaning given by section 222;

"Local Healthwatch contractor" has the meaning given by section 223.""

238ZM: Clause 185, page 184, line 7, after "organisations" insert "or contractors"

238ZN: Clause 185, page 184, line 11, after "organisation" insert "or a Local Healthwatch contractor"

238ZP: Clause 185, page 184, line 12, leave out subsection (7) and insert—

"(7) In subsection (4), in paragraph (a), after "section 221(1)" insert "or Local Healthwatch arrangements"."

238ZQ: Clause 185, page 184, line 13, at end insert—

"( ) After subsection (5) insert—

"(5A) In this section—

"Local Healthwatch arrangements" has the meaning given by section 222;

"Local Healthwatch contractor" has the meaning given by section 223.""

238ZR: Clause 185, page 184, line 16, after "organisations" insert "or contractors"

238ZS: Clause 185, page 184, line 19, after "organisation" insert "or a Local Healthwatch contractor"

238ZT: Clause 185, page 184, line 23, leave out "or in pursuance of"

238ZU: Clause 185, page 184, line 24, at end insert—

"(7A) For the purposes of this section, something is done by a Local Healthwatch contractor if it is done by that contractor in the carrying-on, under Local Healthwatch arrangements, of activities specified in section 221(2)."

238ZV: Clause 185, page 184, line 24, at end insert—

"( ) In subsection (8), before the definition of "overview and scrutiny committee" insert—

""Local Healthwatch arrangements" has the meaning given by section 222;

"Local Healthwatch contractor" has the meaning given by section 223;""

Amendments 238ZG to 238ZV agreed.

Clause 186: Dissolution and transfer schemes

Amendment 238ZW

Moved by

Earl Howe

238ZW: Clause 186, leave out Clause 186

Amendment 238ZW agreed.

Clause 187 : Annual reports

Amendments 238ZX to 238ZZH

Moved by

Earl Howe

238ZX: Clause 187, page 185, line 29, leave out subsection (2) and insert—

"(2) In subsection (2), omit "by a local authority with another person ("H")"."

238ZY: Clause 187, page 185, line 33, leave out sub-paragraph (i)

238ZZ: Clause 187, page 185, line 35, leave out sub-paragraph (ii) and insert—

"(ii) omit ", for each local involvement network,""

238ZZA: Clause 187, page 185, line 37, leave out sub-paragraph (iii) and insert—

"(iii) for "the network", in the first place it appears, substitute "the Local Healthwatch organisation",

(iiia) for "the network", in the second place it appears, substitute "the organisation","

238ZZB: Clause 187, page 185, line 39, leave out "or (as the case may be)" and insert "the arrangements or arrangements made"

238ZZC: Clause 187, page 185, line 40, leave out paragraph (b)

238ZZD: Clause 187, page 185, line 41, leave out paragraph (c) and insert—

"(c) omit sub-paragraph (ii),"

238ZZE: Clause 187, page 186, line 3, leave out subsection (4)

238ZZF: Clause 187, page 186, line 13, leave out "or H in respect of the organisation" and insert "in its capacity as such, and the amounts spent by its Local Healthwatch contractors in their capacity as such,"

238ZZG: Clause 187, page 186, line 31, leave out "or" and insert "the arrangements made under section 221(1) or arrangements made"

238ZZH: Clause 187, page 186, line 33, at end insert—

"( ) In subsection (9), after the definition of "financial year" insert—

""Local Healthwatch contractor" has the meaning given by section 223;"."

Amendments 238ZX to 238ZZH agreed.

Clause 188 : Transitional arrangements

Amendments 238ZZJ to 238ZZL

Moved by

Earl Howe

238ZZJ: Clause 188, page 186, line 43, leave out from "the" to end of line 45 and insert "Local Healthwatch organisation for the authority's area."

238ZZK: Clause 188, page 187, line 1, leave out subsection (3) and insert—

"(3) A scheme under this section may make provision for rights and liabilities relating to an individual's contract of employment; and the scheme may, in particular, make provision which is the same as or similar to provision in the Transfer of Undertakings (Protection of Employment) Regulations 2006 (S.I. 2006/246).

(3A) A scheme under this section may provide for the transfer of property, rights or liabilities—

(a) whether or not they would otherwise be capable of being transferred;

(b) irrespective of any requirement for consent that would otherwise apply.

(3B) A scheme under this section may create rights, or impose liabilities, in relation to property, rights or liabilities transferred.

(3C) A scheme under this section may provide for things done by or in relation to the transferor for the purposes of or in connection with anything transferred to be—

(a) treated as done by or in relation to the transferee or its employees;

(b) continued by or in relation to the transferee or its employees.

(3D) A scheme under this section may in particular make provision about continuation of legal proceedings."

238ZZL: Clause 188, page 187, line 8, at end insert—

"( ) A scheme under this section may include supplementary, incidental and consequential provision."

Amendments 238ZZJ to 238ZZL agreed.

Amendment 238ZZM

Moved by

Earl Howe

238ZZM: After Clause 188, insert the following new Clause—

"Consequential provision

(1) In the Schedule to the Public Bodies (Admission to Meetings) Act 1960, after paragraph (bk) (as inserted by paragraph 2 of Schedule 13) insert—

"(bl) Local Healthwatch organisations, as regards the carrying on of activities specified in section 221(1) of the Local Government and Public Involvement in Health Act 2007 (local care services);".

(2) In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975, at the appropriate place insert—

"Director of a Local Healthwatch organisation."

(3) In Part 3 of Schedule 1 to the Northern Ireland Assembly Disqualification Act 1975, at the appropriate place insert—

"Director of a Local Healthwatch organisation."

(4) In Part 2 of Schedule 1 to the Freedom of Information Act 2000 (local government), after paragraph 35D insert—

"35E A Local Healthwatch organisation, in respect of information held in connection with—

(a) arrangements made under section 221(1) of the Local Government and Public Involvement in Health Act 2007, or

(b) arrangements made in pursuance of arrangements made under section 221(1) of that Act."

(5) In section 65H of the National Health Service Act 2006 (NHS foundation trust special administration provisions: consultation requirements), in subsection (8), for subsection (e) substitute—

"(e) a Local Healthwach organisation;".

(6) In section 4 of the Health and Social Care Act 2008 (matters to which the Care Quality Commission must have regard)—

(a) in subsection (1)(c)—

(i) for "local involvement networks" substitute "Local Healthwatch organisations or Local Healthwatch contractors", and

(ii) omit "in their areas".

(b) for subsection (3) substitute—

"(3) In subsection (1)(c), "Local Healthwatch contractor" has the meaning given by section 223 of the Local Government and Public Involvement in Health Act 2007.""

Amendment 238ZZM agreed.