Health and Social Care Bill

Report (3rd Day)

Relevant documents: 18th and 22nd Reports from the Constitution Committee

Clause 19 : Regulations as to the exercise of functions by the Board or clinical commissioning groups

Amendment 38A

Moved by ***Baroness Masham of Ilton***

38A: Clause 19, page 14, line 9, at end insert-

"( ) The regulations must require the Board to include in terms and conditions prepared by virtue of subsection (5)(a) provision for a requirement to be placed upon any organisation that enters into a commissioning contract to provide healthcare with the Board or with a clinical commissioning group to take all reasonable steps to ensure that a patient or, in the event of death or incapacity, their next of kin, is fully informed about incidents which occur as a consequence of providing the contracted healthcare to that patient where the incident has resulted in-

(a) any injury to a patient which, in the reasonable opinion of a health care professional, has resulted in-

(i) an impairment of the sensory, motor or intellectual functions of the patient which is not likely to be temporary,

(ii) changes to the structure of a patient's body,

(iii) the patient experiencing prolonged pain or prolonged psychological harm, or

(iv) the significant shortening of the life expectancy of the patient; or

(b) any injury to a patient which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent-

(i) the death of the patient, or

(ii) an injury to the patient which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph (a)."

Baroness Masham of Ilton: My Lords, in moving Amendment 38A, I must explain to your Lordships why it is so important. I wish only that the Minister, the noble Earl, Lord Howe, was moving it.

When legislation is before your Lordships it is our duty to try to improve it. For years there has been a serious cover up and a closing of ranks in many cases when something has gone wrong with patients' treatment and they or their next of kin have not been kept informed. If there is not openness and honesty, there could be years of frustration and consternation resulting from trying to find the truth through litigation. The only winners are the lawyers.

Last Monday at 8 pm on Radio 4, and today, there was a programme entitled "Doctor-Tell Me the Truth". The programme explores how patient safety can be improved by doctors admitting to mistakes. In some states in America, medical practitioners must be open about their errors. Instead of increasing litigation, this has lessened it.

I was involved through the Patients Association with some of the next of kin of the patients who tragically died in the Mid Staffordshire NHS Foundation Trust hospital. I congratulate the Government on holding a review into the hospital, where the culture was the very worst and there was a fear to disclose the truth. Surely it is time we put something into legislation to help change this culture.

I was sorry that the amendment which I previously moved-which would have introduced a statutory obligation to provide a duty of candour applying to all providers registered with the Care Quality Commission-did not succeed. However, it was made clear by the Minister that the CQC could not undertake this role. Perhaps it has too much to do satisfactorily and it is just not up to it.

The Minister, the noble Earl, Lord Howe, said:

> "I remind the House that the Government's preferred position is to place a duty of candour in the NHS standard contracts. We have chosen that route because we feel that it has the best chance of working. The view that we have taken, on

> the basis of clinical advice, is that responsibility for ensuring openness needs to rest as close to the front line as possible, rather than being the responsibility of a remote organisation such as the CQC".-[*Official Report*, 13/2/12; col. 591.]

An independent body still seems to me to be the best option as it is transparency and honesty that we need, and front-line medical personnel may still try to cover the mistakes made by members of their profession. I hope not.

Amendment 38A covers what the Government say is the best route to go down. I have had letters imploring me not to give up as so many members of the public, who have been patients or who are their next of kin, have had bad experiences and feel now is the time to change this culture of fear and secrecy. The amendment makes provision for,

> "a requirement to be placed upon any organisation that enters into a commissioning contract to provide healthcare with the Board or with a clinical commissioning group to take all reasonable steps to ensure that a patient or, in the event of death or incapacity, their next of kin, is fully informed about incidents which occur as a consequence of providing the contracted healthcare to that patient where the incident has resulted in"-

and the amendment goes on to mention various harms. If the amendment is not quite correct, perhaps the Minister would accept it and correct it for Third Reading. It would be a start to something that must happen if patients and families are to have much-needed trust in the professionals who care for them. I beg to move.

Lord Walton of Detchant: My Lords, I added my name to this amendment for one reason and one reason only: in the hope of seeking assurances from the Minister. When I first joined the General Medical Council in 1971, the president was the late Lord Cohen of Birkenhead, who was a wonderful man. He was a fine physician, but he was an autocrat and his views were very traditional and in some respects, I have to say, somewhat backward. He told me, "Never apologise to a patient. The lawyers will get after you". He told me, as a young man, "Never speak to the press or to the television. They will misquote you always". Happily, since that time the General Medical Council has progressively changed its view. Now the recommendation made to all medical practitioners is that, if you have made a mistake, if you have committed an error, it is your duty to apologise to that patient sincerely. An apology does not mean an admission of liability; it is simply a sincere apology for a mistake. I hope that is the case in respect of all other healthcare professionals whose activity is regulated by law. I would like an assurance from the Minister that that is the case.

The purpose of this amendment, which has been so well proposed by my noble friend, is to confer on health bodies, whether clinical commissioning groups, independent foundation trusts or other organisations providing medical care, a similar obligation and, indeed, the duty to apologise for errors that have occurred under the auspices of those organisations. I simply ask the Minister whether, in the contracts that these bodies hold with the NHS, such an obligation is a part of the contract. If it is, it may not be necessary to have such an amendment on the face of the Bill. I hope the Minister can give me those assurances.

Lord Harris of Haringey: My Lords, I support this amendment because I believe that it is a sincere attempt by the noble Baroness, Lady Masham, to help the Government out. I do not intend to repeat the arguments that we had a few days ago on Report about placing on institutions a rather stronger statutory obligation to inform patients where mistakes had taken place, partly because we have had that debate. During that debate, the Minister repeatedly expressed the view that the objectives of the amendment could be achieved by placing a contractual obligation on organisation to do this. This amendment quite simply requires that that contractual obligation takes place. I am assuming, therefore, that the Minister will accept the amendment, because it does exactly what he said he wanted to do in his previous speech.

The amendment also expresses the concerns raised by a number of your Lordships in Committee and one or two on Report that perhaps placing the duty and obligation directly on organisations and the individuals involved would be inappropriate and that that would provide too rigid a framework. However, as the amendment does what the Government said would solve the problem, I hope that the Minister will indicate that he is happy to accept it in this form.

The reason why I think that it is helpful to the Government is, as may not have escaped the Minister's attention, a certain amount of criticism of the Department of Health and of this Bill is prevalent at the moment. For example, a letter was published in the *Telegraph* this morning which said:

"The Coalition Government promised to ensure greater NHS accountability to patients and the public. We believe this aspiration has now been abandoned".

That was signed by a large number of people active in representing the interests of patients around the country. It is not specifically about this issue; it is about an issue that we will come on to very shortly in terms of HealthWatch. But there is a very widespread concern that, despite all the rhetoric that we have heard from the Government about "no decision about me without me", that aspiration has been lost in this Bill.

Part of the way of getting patients to have confidence in their health service is through the knowledge that if something goes wrong the fact will be shared with them. The Government said that they did not want a statutory obligation to be placed on individuals or institutions to do that, but they said that they would like contractual arrangements to be put in place. This amendment makes sure that those contractual arrangements are put in place, and I would have thought that the Government would want to accept it so as to demonstrate that even now there is some good faith left around their desire to put patients at the centre of the NHS changes.

Baroness Finlay of Llandaff: My Lords, I support this amendment and urge the Government to accept it as it is written. I hope that the Government can see that this is very helpful; it fits with the points made by the Minister in his summing up in response to the previous amendment tabled by my noble friend Lady Masham about there being agreement on the importance of openness and candour in healthcare. The Minister went on to say that,

> "the NHS could only call itself a world-class health service if it embraced openness wholeheartedly".-[*Official Report*, 13/2/12; col. 590.]

He added that there was agreement that something needed to change.

The beauty of the way in which the amendment is worded is that it distinguishes between major and minor occurrences. It emphasises the true duty of candour to disclose events that have affected a patient either medically or physically and that may have long-term effects. It does not focus in any way on anything trivial and requires the contractual duty of candour to be put into the contracts, which was exactly the content of the Minister's summing-up speech last time.

Lord Faulks: My Lords, I remember well the degree of consensus in your Lordships' House when we debated the statutory duty of candour-namely, that everything should be done to embed in the NHS the culture of openness and to be against any form of cover-ups. However, as I said on that occasion, the world has moved on a little since the days of Lord Cohen-with great respect to the noble Lord, Lord Walton. A number of initiatives have resulted in greater openness by clinicians and a sense of responsibility, which one can find right across the health service. All is not perfect, of course. The duty of candour has been much discussed in academic circles, and the noble Baroness referred to the experience in America where some states-not many-have a duty of candour. But there are very serious arguments that run to the effect that imposing a duty of candour can have adverse effects in that many are thereby encouraged to sue in circumstances where they might not otherwise have sued.

The form of this amendment is certainly good in the sense that it focuses on the serious rather than the trivial. None the less, it does contain the word "incidents", which is extremely difficult to define. In what circumstances does a clinician, or those employing a clinician, have to go through the processes that the amendment involves? From what the noble Earl said on the last occasion, the Government clearly take the matter of candour extremely seriously. There is a consultation about it and, in due course, there will be reflections of that duty in the contract. Although I am entirely sympathetic to what lies behind this amendment, I am a little concerned that imposing terms, with the inevitable imprecision that this form of amendment carries with it, is not at the moment the answer.

Baroness Tyler of Enfield: My Lords, I, too, spoke briefly in the debate last time about the statuary duty of candour. At the end of that debate the Minister gave a number of important reassurances. One was to review the contractual duty in a specified period to see how effectively it was working. The second was to do with further work to explore how this whole issue could be taken forward in the area of primary care-an area which I, and certainly colleagues on these Benches, still feel is extremely important. I would be grateful if the noble Lord, in summing up, could say anything further about how a contractual duty of candour would apply to those in primary care. Also, could he give any further reassurances at this stage about the reasons why he feels that a contractual duty of candour in the way which is set out in this particular amendment would be effective?

Lord Campbell of Alloway: I very briefly take the point made about an apology for the mistake. I do this because when I was an advocate I appeared before the BMA for quite a lot of medical professionals. If your client says, "I am terribly sorry for my mistake", it puts one in a very difficult position; the advocate must show that the mistake had nothing to do with the result. I will not take up time, but say merely, as an erstwhile advocate, watch it.

Lord Faulks: Before the noble Lord sits down, could he confirm that, since the Compensation Act 2006, an apology is no longer deemed to be an admission of liability?

Baroness Hollins: My Lords, I support the amendment, particularly because it draws attention to the point that often patients experience prolonged psychological harm after an incident, something that is well understood across the whole of the medical field. Such psychological harm is often overlooked. However, there is plenty of evidence that an honest and prompt apology can do so much to help the person and their family going forward. It is fair to say that delaying a response is very much like denying a response. The timeliness of a response is critical.

Lord Turnberg: My Lords, As someone who taught medical students for many years that it is very important to be absolutely open and candid with your patients, and that, if something has gone wrong, to explain it in full to the patients and their relatives-explaining that that is not necessarily an admission of guilt in some way-I am very keen on the sort of sentiment that is being expressed in this amendment. I am particularly keen on the GMC imposing on doctors the duty of being open. I am all behind the sentiments of this amendment. I have some anxiety, though, about how this can be put into law. How can you legislate for someone to be candid? How will it work? How do you know that someone has been candid or not? There is a great deal of subtlety about this candour and about putting it into law as a duty on every occasion. I am slightly apprehensive about the amendment, even though I support everything about the principle.

Lord Winston: My Lords, I find it very difficult, as I have said before, to accept or support this kind of amendment, but I strongly believe in candour and I totally support what many noble Lords, including my noble friend Lord Turnberg, have said around the House. However, there are major problems with putting this kind of amendment into legislation, which would make it extremely difficult to be reasonable. There would be real risks of serious psychological harm to quite a lot of patients. One of the last things we want to do is to involve patients in a perceived injustice or perceived negligence which turns out to fail miserably in the courts of law. I have seen that as horribly damaging with patients I had in the past when I was a medical practitioner, which I am of course no longer.

The other issue not adequately dealt with in this amendment is that of time. At what stage is it justified no longer to be candid? Should somebody who, let us say, sees something from that same health authority a year or two later, or three or four, still be candid about what they think may have gone wrong, or where they are not absolutely certain that it has gone wrong? There is a colossal difficulty in trying to enforce this. Far better is the idea of having some kind of code of practice, to which I think my noble friend Lord Turnberg referred, which ought to be acceptable to doctors.

When I was a trainee surgeon, we did innumerable partial gastrectomies. We now know that that operation was really mutilating and totally wrong; it actually resulted in many people losing weight and not being able to hold down a proper diet. Subsequently, of course, peptic ulceration could be treated by a simple antibiotic therapy. Now, at what stage does that treatment become established or a gastrectomy become a negligent operation? These are very difficult things to define, and I urge that we should not write this proposal into law in the way that is proposed.

Baroness Wheeler: My Lords, we had a long debate on this very important issue of the duty of candour before the Recess, and I do not intend to take up very much of the House's time on this amendment by responding to the issues that we covered then, or by repeating our views on why we are concerned that the Government's current proposal for a contractual duty will not address the need for the huge cultural change in the NHS that has to take place in order to ensure openness and honesty when things go wrong in the care and treatment of patients.

Nevertheless, I hope that the Minister will accept the case for regulations on including the duty of candour in commissioning contracts. We on these Benches emphasise our commitment to trying to help to make the contractual duty work. I therefore place it on record that we welcome the Minister's reassurance during the previous debate that he will come back to the House on the outcome and actions resulting from the current government consultation on the contractual duty. I also hope that he will be magnanimous in the victory that he had before the Recess in the vote rejecting statutory requirement by standing by his assurances on a future review of the effectiveness of the contractual duty, after an appropriate period, and whether its effectiveness is being held back by the lack of statutory provision. My third hope is that the NHS Commissioning Board will issue clear and strong guidance to assist CCGs in this matter, and I look forward to the Minister's response.

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, this has been another very good debate on the duty of candour. As we have discussed previously, the Government's position is that the NHS contracts are the most appropriate mechanism through which to implement a further requirement for openness. Amendment 38A proposes that the contractual duty of candour should be given a specific reference in primary legislation. I hope that I can satisfy the House on this and that the undertakings I am about to give the noble Baroness from this Dispatch Box will reassure her sufficiently to enable her to withdraw the amendment.

I give an assurance to the House that the Government propose to use the provisions in Clause 19 relating to the standing rules to specify that the contractual duty of candour must be included in the NHS standard contract, developed by the NHS Commissioning Board. If that assurance is accepted, as I hope it will be, a specific reference is not required to ensure that a contractual duty of candour is imposed. The question, therefore, is whether, despite my assurance, it is necessary or appropriate to include a provision in Clause 19. I have given this proposal substantial thought, and I admit that it is one which on the surface has some appeal. I have spent a good deal of time discussing the matter with noble Lords as well as with Professor Sir Bruce Keogh, the NHS Medical Director.

Let me explain where my deliberations have taken me. At present there is a very wide range of issues that we incorporate into the standard contract. These include issues of paramount importance to the quality and safety of healthcare. For example, the contract is used as one of the mechanisms that we are using to drive improvements in prevention of venous thromboembolism, or VTE. It has been estimated that every year 25,000 people in England die from VTE that they have contracted in hospital. We also use the standard contract for driving improvements in cancer treatments and referrals in healthcare-associated infections in issues such as consent and many other areas.

As the Bill stands, it does not contain a list of the requirements which are to be included in the standard contracts, and for good reason. The Bill should not contain unnecessary detail. On top of that-and I think that this is perhaps a more important point-there should be sufficient flexibility for the Secretary of State and the board to consider and draft appropriate terms and conditions and adapt them to changing circumstances.

The question I pose to myself is this: if, through a reference to the duty of candour, we are to start down the road of specifying particular quality and safety contractual requirements in the Bill, then where do we stop? Just including the few issues that I have briefly mentioned, without any others, means that we will almost certainly land up with a cumbersome and unwieldy list. There are many other areas besides those which some might see as having a similarly valid claim to be mentioned. We should not use primary legislation to cherry-pick priorities to the detriment of other equally important areas.

We have further concerns about precisely what the amendment would require the Secretary of State to provide in the standing rules. We are still looking at what the appropriate contractual term should be in the light of the recent consultation that was mentioned. Imposing a duty in the Bill to adopt a specific formulation, as the amendment would have us do, constrains our ability to take proper account of the consultation and the engagement that we have had with stakeholders-it risks forcing us to implement an inappropriate requirement-and from easily improving it in the future, if the evidence supports that.

I was struck by the very powerful speech of my noble friend Lord Faulks during our last debate on this topic, and indeed by his words today, when he challenged the House to consider the difficulties involved in drafting a duty which adequately encapsulates these obligations. The noble Lord, Lord Winston, was very wise in what he said. For example, how would we specify the types of incidents to which any contractual requirement would apply? The contractual duty and provision in the regulations must be neither too wide nor too narrow in order to be effective and proportionate. We need the flexibility to consider this in more detail.

The noble Baroness's amendment would have us require particular steps to be taken in particular defined circumstances and adopt a particular definition of the incidents to be covered by the duty of candour. I am extremely uncomfortable with that. Apart from anything else, we specifically asked this question in the public consultation, so we would be undermining that process if we were not properly to consider the responses we received. I really think, therefore, that it would be better to let that consultation guide us as to the precise way in which the duty should be framed. It is for those reasons that, after considerable thought, I can tell the noble Baroness that I do not think it would be wise for us to accept Amendment 38A.

The noble Lord, Lord Walton, asked about the duty placed on individual doctors within a trust. Doctors are expected to follow the code of practice laid down by the GMC, as he will know, and failure to do so may lead to action against a doctor by the regulator in the exercise of its statutory powers. I can confirm to the noble Lord that the code is not just words; it is backed up by real regulatory force. Indeed, I have the wording of the code in front of me:

"If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects".

There are similar provisions in the Nursing and Midwifery Council code as well. My noble friend Lady Tyler asked about the time period for the review of the contractual duty that I promised last time we debated this. My view at present is that about three years from the implementation of the duty would be an appropriate period. We will be setting out in more detail when we propose to conduct that review when we respond to the consultation.

I reiterate on the record the Government's and my commitment to introduce a contractual duty of candour to require openness and transparency in the NHS. I understand the strength of feeling on the topic; indeed, it is for exactly that reason that I promised in our earlier debate that the Government would undertake a review in future of the effectiveness of the contractual duty of candour, and to include that within a specific analysis of whether its effectiveness was being substantially held back by the lack of a reference in primary legislation. If that review were to highlight that this was indeed happening, the Government would give that fact significant consideration and take it fully into account in the context of any future primary legislation. On top of that, I reiterate the commitment that I have given today that the Government intend to use the "standing rules" regulations to specify that the contractual duty of candour must be included in the NHS standard contract. I hope that I have provided the noble Baroness

with cast-iron reassurance upon this topic, and I therefore ask her to withdraw her amendment.

Baroness Masham of Ilton: My Lords, I thank all noble Lords who have spoken. I think that because I was thanking the Minister last time, I forgot to thank all those who had spoken then, so I thank them now as well.

This is a complicated Bill, and I do not think it is a very popular one-certainly not outside your Lordships' House. I worry intensely that while patients were said to have been centred in the Bill, in fact they are getting less and less so. However, we will come on to that later.

I am passionate about patient safety. I thank the Minister for his assurances. We have moved on a little. Things take a long time, but a lot of people now feel that doctors, patients, and all those looking after them should be a team. I hope that this will happen.

I am pleased that the GMC has come out against the gagging clause. It was terrible and extremely confusing for doctors when they were told by managers that they were not allowed to say when something had gone wrong. I am glad. We are moving on, and I hope that this debate has been useful. With that, I beg leave to withdraw the amendment.

Amendment 38A withdrawn.

Amendment 38B

Moved by ***Lord Hunt of Kings Heath***

38B: Clause 19, page 14, line 32, at end insert-

"(8A) The standing rules under subsection (1) shall make provision as to how clinical commissioning groups are required to register, manage and report upon conflicts of interests of both members and employees of a clinical commissioning group, or any individual engaged by a clinical commissioning group to be involved in any part of the process of commissioning NHS services ("the Conflict and Financial Interests Rules").

(8B) The Secretary of State shall consult upon and then publish a Code of Conduct for members of clinical commissioning groups concerning the registration of pecuniary and non-pecuniary

interests by members of a clinical commissioning group, and setting out how clinical commissioning groups shall manage actual or potential conflicts of interests amongst its members, which shall include provisions concerning the provision of services (other than NHS services) to NHS patients.

(8C) The Conflict and Financial Interests Rules shall include the following provisions-

(a) a duty on members of a clinical commissioning group to abide by the terms of the Code of Conduct to be published by the Secretary of State under subsection (8B) hereof;

(b) that each clinical commissioning group shall maintain a register of pecuniary and non-pecuniary interests of members of the clinical commissioning group;

(c) a requirement that each member of a clinical commissioning group shall register all of his pecuniary and non-pecuniary interests in the Register unless the said interest shall be within a de minimis classification set out in the Regulations, and shall keep the said register up to date;

(d) a requirement that the register of interests of each clinical commissioning group shall be published and made available for public inspection;

(e) a requirement that, unless approved by the Board, a clinical commissioning group shall not be entitled to enter into any arrangements to commission healthcare or other services with any person where any member of the clinical commissioning group has a financial interest or link to that person of a type set out in Regulations ("a Conflicted Arrangement");

(f) a procedure ("the Exemption Procedure") under which a clinical commissioning group shall be entitled to request an exemption from the Board so as to permit the clinical commissioning group to enter into any a Conflicted Arrangement;

(g) that the Exemption Procedure shall require the clinical commissioning group to publicise the application for the exemption and to permit any objections thereto to be considered by the Board;

(h) that the Exemption Procedure shall provide that, after considering the merits of the individual application, the Board shall be entitled to approve the arrangement if but only if the Board is satisfied that the proposal to enter into any such arrangement has been the subject of an open and transparent procurement process, that it provides the best value for money for the clinical commissioning group and that there are appropriate

safeguards proposed by the clinical commissioning group to manage any conflict of interest in the management of the said arrangement;

(i) that no member of a clinical commissioning group shall be permitted to take any part in any discussion of or decision making process concerning any arrangement or proposed arrangement with a provider of services with whom that person has a registerable interest;

(j) a procedure for complaints to be made to the Secretary of State by any person who alleges that a member of a clinical commissioning group has acted in breach of the Code of Conduct or in breach of the Conflict and Financial Interests Regulations;

(k) a procedure for the Secretary of State to appoint an adjudicator to investigate and to rule upon any such complaint; and

(l) for the adjudicator to be able to impose sanctions on any member of a clinical commissioning group has been found by an adjudicator to have acted in breach of the Code of Conduct or in breach of the Conflict and Financial Interests Rules including-

(i) such financial sanctions as the Secretary of State shall consider appropriate;

(ii) suspension of such a person from being a member of a clinical commissioning group;

(iii) removal of such a person from current membership of a clinical commissioning group;

(iv) a bar on such a person being a member of a clinical commissioning group for a period of up to 10 years;

(v) the referral to the Board for action to be taken against any individual who is a performer under the National Health Service (Performers List) Regulations 2004; and

(vi) the suspension or termination of any contract or arrangement for the provision of NHS services that may exist between the Board or any clinical commissioning group and that person or any partnership, company or other organisation with whom that person shall have a registerable interest.

(8D) Where any contract or other arrangement is suspended or terminated by the action of an adjudicator following an adjudication under sub-section (8C)(I), no other person shall be entitled to assert any legal right or make any claim for damages or financial

compensation on any other basis whatsoever against the Board or any clinical commissioning group as a result of the said adjudication."

Lord Hunt of Kings Heath: My Lords, we return to one of the most important matters in the Bill: clinical commissioning groups and their effective corporate governance, or lack of it-specifically, the question of how conflicts of interest are to be dealt with. In his letter of 16 February to putative clinical commissioning groups, the Secretary of State spoke enthusiastically of the freedoms that they were to receive. There can be little doubt that they are one of the most important features of this Bill. They are to be given a huge amount of money. They are to be given freedom to commission services. They are to be given freedom to decide when and how competition should be used. Because clinical commissioning groups will exercise such important roles, I would have thought that public interest demands that the principles of good corporate governance should apply as much to them as to any other public body.

In Committee, the noble Lord, Lord Kakkar, drew attention to the seven principles of public life and asked whether they applied to clinical commissioning groups. I asked the noble Earl, Lord Howe, whether independently appointed non-executives would be on the board of clinical commissioning groups. I also asked how conflicts of interest were to be dealt with. He said that the Bill places a duty on the Secretary of State,

> "to publish a code of conduct for CCGs, incorporating the Nolan principles on public life".-[*Official Report*, 14/11/11; col. 564.]

To my suggestion that each clinical commissioning group board should have on it a majority of non-executives and be independently appointed, he said-disappointingly-that each group must only have at least two lay members and that one must be either the chair or deputy chair of the governing body.

On the conflicts of interest, the noble Earl said that the Bill had three safeguards: statutory requirements on clinical commissioning groups to make arrangements to manage conflicts of interest, governance arrangements, and specific regulations on good practice in the procurement and commissioning of healthcare services. Is that sufficient? I do not think that it is. These groups are unique. In essence they represent groupings of small businesses which have had handed over to them billions of pounds, a proportion of which they can spend on primary care services. Sometimes these are to be provided in the surgeries of GPs who are members of the clinical commissioning group, or perhaps are to be provided by companies in which GPs within a clinical commissioning group may have a financial interest. The potential conflict of interest is so obvious that it surely begs the question as to why the Government are not putting safeguards on this matter in the Bill.

My amendment is a lengthy one, but I hope comprehensive. It sets up a register of pecuniary and non-pecuniary interests. It places an obligation on clinical commissioning groups to register. It prevents any arrangements being entered into between a clinical commissioning group and a party with whom a member has an interest. It provides for an exemption procedure whereby the board could approve the arrangement if it was open and transparent. It prohibits a member of a clinical commissioning group taking part in discussions with any business in which he or she has an interest. It also provides a process under which an adjudicator appointed by the Secretary of State can adjudicate on complaints about members of clinical commissioning groups breaching the code of conduct, which is provided for in my proposed new subsection (8C). The sanctions include removing the individual as a member of the clinical commissioning group and the termination of any contract which has been put in place between the group and anyone with whom the member has a registerable interest.

A clinical commissioning group board will have a majority of GPs sitting on it. They are involved in running businesses which are largely dependent on the NHS for their income. The role of a clinical commissioning group will be to commission services, some of which will be commissioned from those GPs who are members of that group or, as I said earlier, from companies in which some of those GPs may well have an interest. Independent lay members will be in a minority and we have yet to receive assurance that they will be independently appointed. We have not even been assured that the chairman of the clinical commissioning group will be an independent lay member. It will have the weakest corporate governance of any public body in this country.

We know that over the past 20 or 30 years any number of inquiries have shown the problems of poor corporate governance. After all, the Nolan commission was started because of such problems. This will explode in the Government's face unless they strengthen the corporate governance of clinical commissioning groups. If you combine these weak corporate governance arrangements with the ability of a clinical commissioning group to make decisions that could be to the financial advantage of GPs who are members of that group, you are heading for trouble. We need robust safeguards and they ought to be in the Bill. I beg to move.

Baroness Barker: My Lords, noble Lords will recall that in Committee I too highlighted the issue of conflicts of interest. I did so because, like many other noble Lords, I had listened to and read the briefings sent by the professional bodies, many of which raised fears and concerns about conflicts of interest. Like many other noble Lords, I believe it is important not only that members of the public have faith in the integrity of the decisions being made by CCGs but that members of the professions believe in those decision-making processes and feel able to participate in them. They should also have

the protection of good governance and good conflict-of-interest policies to enable them to carry out what will be a difficult role.

Before we look at the detail of this, it is important to remind ourselves a little of the context. There are conflicts of interest in the National Health Service now. There always have been, as anyone who has ever sat around the table at a joint finance meeting at which every single person has an interest in the discussion will know. It may not be a direct financial interest; it could be about a post, a project or money. Managing conflicts of interest is something that the NHS and PCTs do now. That is not to say that we should not take the opportunity of the Bill to make the principles according to which the NHS should act more overt. They should be the highest of principles.

It is for that reason that my colleagues and I raised the matter in Committee. We then drafted a set of amendments that are in this group-Amendments 84, 89, 91, 92, 93 and 116. I am very grateful to several noble Lords, including the noble Lord, Lord Newton of Braintree, who looked at those amendments with the seasoned eye of an ex-Health Minister. His response was, "Very good but an awful lot of this needs to be in regulation, not in the Bill". I took his comments to heart, which is why my colleagues and I withdrew those amendments on Friday and noble Lords now have Amendments 79A, 82A, 86A and 86B before them on the Marshalled List.

It is also important that noble Lords understand one particular point about the interpretation of the Bill. A great deal of anxiety has been expressed by some of the professional bodies about the role of commissioning support organisations. Noble Lords may recall that I raised that in Committee. I have been in discussion with several members of the professions to try to understand the source of that concern. As far as I can understand, there is a view within some of the professional bodies that commissioning support and the commissioning of services are one and the same thing, whereas the Minister was at great pains in Committee to stress that they are two different processes that go side by side.

Noble Lords may have seen a briefing by Professor Allyson Pollock on her interpretation of Schedule 2. Would the noble Earl, Lord Howe, in his response to these amendments, talk particularly about the role of commissioning support? There is a view outside, which is informed by some of those briefings, that people who are not clinicians will have a responsibility for commissioning clinical services. In Committee he was at pains to stress that that was not the case; that it would be members of CCGs only who had that responsibility and that they would be given support to do that only by CSOs.

I return to the issue of conflicts of interest. They are extremely difficult things to legislate for because they take a number of different forms. On the ground, a conflict of interest

can be financial or non-financial-it is a difficult thing to define in legislation. In our amendments, and particularly Amendment 79A, we state that there must be a register of interests of members of a CCG, the governing body, its sub-committees and its employees. Noble Lords might find it helpful to know that, for the purposes of the legislation, "employees" covers people who work as consultants. I do not mean medical consultants, but people who work in a consultancy capacity to the CCG. Under the amendment, they must publish registers of those interests and ensure public access to them; and the registers must be kept up to date, with information being placed on them within 28 days. Why is that important? People's interests change and these organisations will be in the business of giving out contracts to providers. It is therefore important that if someone has a material interest and that interest changes-particularly around the time of the contract being issued-this is brought to public attention quickly.

Proposed new subsection (4) in our Amendment 79A states that CCGs,

> "must make arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making processes".

It is extremely important that these groups not only set out to uphold the highest standards but that they are seen to uphold them.

Lord Hunt of Kings Heath: My Lords, I am grateful to the noble Baroness. Could she clarify what happens in the situation that she has laid out in these amendments if a member of a CCG does not do the right thing? Are there any sanctions in her amendment?

Baroness Barker: The noble Lord is quite right and I will come on to that.

These amendments also refer to the board publishing guidance and what that guidance would include. As I understand it, members of CCGs who are in material or consistent breach of a conflict-of-interest policy might be referred to their professional body. Amendment 86A is a regulation-making power. It is under that power that many of the important details could be included. They would, I imagine, include issues such as the ones which the noble Lord has just raised about the sorts of sanctions which CCGs should include in their guidance and policy.

Lord Hunt of Kings Heath: My Lords, with respect to the noble Baroness, she has withdrawn some amendments and put in some substitutes, so I think it is fair to ask her these questions. Without sanctions, this is not going to have any teeth. There is a major concern about corporate governance in CCGs. Surely it would be better to put it on the

face of the Bill rather than, as it seems to me she is doing, leaving it up to CCGs to do the necessary.

Baroness Barker: Not entirely, my Lords. As I was coming on to say, an important piece of work is that the GMC is updating its guidance on how its members should work in the new setup. It is important that members of bodies such as the GMC, the BMA and other professional bodies are involved, should they wish to be, in setting out the detail of what those sanctions should be. We should end up with something that is effective and workable, as well as principled. The noble Lord's argument does not therefore stand up. Nothing in these amendments would preclude that sort of sanction being put into regulations or guidance.

Our amendments are, admittedly, not as detailed as the amendment of the noble Lord, Lord Hunt, nor do they-as his amendment does-incorporate language from the world of commercial legislation. The terminology of conflicted arrangements and exemption procedures comes from commercial law, and I am not sure that that is appropriate for what we are seeking to do. At the end of this debate we should achieve the objective that all noble Lords are seeking-transparency and accountability around the decision-making processes of CCGs, and the legislation and regulations around them should be sufficiently robust so that not only can members of the public have faith in those procedures but the procedures should be workable. I accept that our previous amendments included provisions that were so draconian that they would not work in practice. We could have ended up in a position whereby the very people who should be making decisions on CCGs would not have been eligible to do so, particularly at the precise moment at which their expertise would be necessary.

Our amendments are not by any means the end of the matter; they are the beginning of a process that should move on further in the discussion on regulations and guidance. That is where much of the detail of this should come to the fore, but the principles that we have set out in these amendments are robust and workable, and I hope that in his reply the Minister will accept them.

Lord Patel: My Lords, I support the amendments relating to conflict of interest and I agree that there needs to be something in the Bill. I will give an example to indicate why I believe that more strongly following a seminar that we attended before the Recess. For those noble Lords who were not there, we had a presentation from a GP who told us, first, that he was salaried, and I therefore presume he did not have a standard general medical services contract, and that his salary came from somewhere else-it may well have come from another general practitioner. He said, secondly, that he was involved in commissioning and, thirdly, that the commissioners had found that the provision of some services in his area was not satisfactory or of the quality that they had asked for-

particularly, in relation to hand surgery. They therefore set up an independent provider of surgical services, of which the GP was a non-executive director. The conflicts of interest are quite obvious: here is a commissioner who is a salaried doctor, and that raises a question. If the commissioning board is to hold the contracts of primary care providers, will they not include those who have a general medical services contract, or will they include those who are salaried? More and more primary care providers are salaried GPs employed by other practitioners. We therefore also need to clarify who will be asked to be a member of the commissioning group: will it be only those who hold the general medical services contract, or will it be all those who provide primary care services? The conflict of interest here is many-fold, and therefore we need to address how it is to be resolved.

While I was, and still am, very attracted to the amendments of the noble Baroness, Lady Barker, because I had not seen those of the noble Lord, Lord Hunt, the question of sanctions needs to be addressed more clearly. I agree with the noble Lord, Lord Hunt, on the need for this question of sanctions to be clarified so that those who may be involved in conflict know from the very beginning how those sanctions will apply to them.

Lord Winston: My Lords, perhaps I may deal very briefly deal with one area of medicine with which the noble Lord, Lord Patel, and I are particularly familiar. One problem raised is that increasingly general practitioners are doing minor surgical procedures; increasingly in practice, often in groups. I know of one large practice in south-east England, for example, that is now carrying out a procedure called a hysteroscopy, which is an endoscopic or telescopic examination of the inside of the uterus. This is quite a specialised procedure designed to identify cancers of the uterus at an early stage. The problem is that general practitioners may well be able to carry out this procedure somewhat more cheaply than gynaecologists in a practising group. Of course, there is clearly a conflict of interest here, because they may well be in the very practice that is also commissioning this procedure, and a patient might perhaps be wrongly given a particular treatment when a slightly more expensive treatment, done elsewhere, may be more effective and reduce the risk of the cancer.

Baroness Finlay of Llandaff: My Lords, this group of amendments and this debate has focused on conflicts of interest. For clinical commissioning groups, conflict of interest will arise where the leaders of the groups have financial interests, but also where private companies which may have separate provider arms competing as a qualified provider are contracted to provide commissioning support. The other area of conflict which has not been addressed is where quality rewards for commissioning are linked to financial

performance of clinical commissioning groups. Further, there are cases where local medical committee officers are key officials in a clinical commissioning group.

The clinical commissioning group is meant to represent the constituent practices. Indeed, there have been articles in the press about commissioning support and commissioning support organisations. Many of those have raised alarm among clinicians who have become increasingly concerned by the talk revealed in the press about the profit to be made by commissioning support organisations. There has also been a realisation that profit going to the commissioning support organisations will reduce the amount of money going into the provision of core NHS services at any level-whether in the community or in secondary care and the hospital sector.

Several amendments are tabled here. The amendment in the name of the noble Lord, Lord Hunt, is very comprehensive and deals with an area which the other amendments do not. There is also an amendment, on which my name is the first, regarding conflict of interest. I can see that Amendment 79A is more detailed than the amendment which I have tabled, and therefore goes further and would be better. However, I am concerned that it does not go quite as far as the amendment in the name of the noble Lord, Lord Hunt, and that some of the principles in there need to be incorporated into Amendment 79A if the Government are minded to accept that amendment. We may have to come back to amend the amendment should it be accepted and incorporated.

My Amendment 102 in this group addresses a quite different aspect of the commissioning process. It aims to ensure that the registered secondary care specialist who is to be included on the governing board of each clinical commissioning group can be someone working within the area that the clinical commissioning group covers, the reason being that a person working in an area will be able to establish integrated care across that area far better than someone who comes from outside. In *Teams without Walls*-a document on which the Royal College of Physicians led but which was written in conjunction with the Royal College of General Practitioners and the Royal College of Paediatrics and Child Health-it was made very clear that the complementary skills of the different groups need to be integrated. There has been quite a lot of concern at the suggestion that the secondary care specialist should not be employed by a local provider and should therefore come from outside the area or even be a retired person.

That concern arises because there will be nobody in the local community who understands that community, who knows the clinicians across the community and, indeed, who has an interest in the patient services for that community. Furthermore, if it is a rural area, such a clinician may be relatively disadvantaged in having to travel many miles to attend meetings and in not being embedded in the healthcare delivery system. It seems to go counter to a localism agenda to insist on taking somebody from outside

the area. Therefore, the amendment is designed to allow a clinical commissioning group to take the best person, whether they are from within or from just outside the area, to drive forward integration and collaborative working. One would hope that a representative from primary care would also be invited on to the trust board within an area so that there was a degree of reciprocity-again, to build bridges rather than to create a division between the primary and secondary care sectors.

Conflicts of interest will have to be declared at every stage, and obviously the secondary care doctor will have no right of veto. The argument that the secondary care doctor from within an area would argue only in favour of their own discipline or trust is fallacious. I have not seen a strong evidence-base for that, given that medical directors and others currently work in an area representing different disciplines. A criterion of the person's job description, appointment and regular appraisal could be that they are seen to represent all providers within an area so that trust is built up across all the providers with which a clinical commissioning group enters into some form of contract.

We have a group of amendments here covering a wide range of aspects of the structure and functioning of clinical commissioning groups. I hope that we will shortly find that a declaration of interests is included in the Bill, in whatever form, and that the Minister will be amenable to revising the rigid stance taken over insisting that the secondary care representative and nurse come from outside the area.

Lord Walton of Detchant: My Lords, this is an exceptionally complex issue and I believe it is absolutely crucial that in some way and in some form the issue of a conflict of interests is covered in the Bill. The membership of clinical commissioning groups will consist very largely of general practitioners, but it is important to remember that GPs are not employed by the National Health Service but are independent contractors. As such, it is therefore inevitable that they will have a pecuniary interest in the activity of the clinical commissioning group. I am aware of a number of general practitioners from large practices who have shares in or part-ownership of care homes for elderly patients. I am also aware of some who have shares in private hospitals and in many other organisations. If we were too rigid about declarations of interest, we could end up excluding virtually every GP from membership of clinical commissioning groups, meaning that CCGs could not really exist. Therefore, the provisions must not be too draconian, but at the same time, it is desperately important that they should protect the public interest and that some mechanism be found to ensure that matters of financial and other public interest are not in any way detrimental to the work of the clinical commissioning groups.

I am therefore very attracted by Amendment 79A, which I believe goes a long way towards covering the major issues concerned with conflicts of interest. The amendment

so ably proposed by the noble Lord, Lord Hunt has many attractive features, but it is immensely lengthy and complex. I appreciate entirely the point that he made about sanctions, but to go back for a moment, the Minister misunderstood me when I was talking about the duty of candour. I fully appreciate that doctors working for clinical commissioning groups, foundation trusts, and so on, have the same duty of candour as defined by the regulations of the GMC as any other doctor. I intended to ask the Minister whether the actual clinical commissioning groups and foundation trusts, as corporate bodies-not the individual employees of those organisations-had the same responsibility of a duty of candour in relation to patients.

Here, of course, the same problem arises in relation to the whole issue of conflict of interest. How is it defined? It is necessary to recognise, as the noble Lord, Lord Hunt, said, that there has to be a sanction. But the same sanctions apply to individual doctors and other healthcare professionals working for clinical commissioning groups. If they were seen to breach the rules laid down in such an amendment on conflicts of interest, they could be called to account by their regulatory authority. The GMC would no doubt take a serious view of anyone who breached that duty under conflicts of interest. It is crucial that the Government should put something about conflicts of interest in the Bill based, I hope largely, on Amendment 79A, which I strongly support. That is an excellent basis on which to go ahead, and I shall be fascinated to hear what the Minister has to say.

Lord Warner: My Lords, I had not intended to speak for very long on this set of amendments but some issues have cropped up which are worth reflecting on, particularly by those of us who have sat in Richmond House and have had to deal with them. It is easy to assume from listening to the debate that we have a wonderful set of arrangements in place to deal with conflicts of interest. That is very far from the case. The noble Lord, Lord Walton, made the point very well that many doctors already do a range of activities-rightly, appropriately and well within their competence-that potentially involve conflicts of interest. One of the great dangers in this area is that we tie ourselves up in a labyrinth of controls that actually work against innovation in an area where science is driving change rapidly. We want people to use their creativity and to change the way they work. We want them to take on new roles. We should not always assume that in doing that they are just seeking to line their pockets. There is a danger that we might do a very British thing and create a large number of rules that will prevent innovation. We had that debate over research and we are in danger of going down the same track in this area.

The other point raised by the noble Lord, Lord Walton, which is very important, is in relation to the role of professional bodies. We had a case-I will not mention the name-of

an eminent businessman doctor who was the chief executive of a large chain of nursing homes. He was taken to the GMC because of something that went wrong in one of the nursing homes for which he had no direct responsibility whatever. Although the governing bodies of the professions have an important role, their role was constructed in relation to the actions of a doctor towards individual patients, not in relation to a doctor who was performing other business and organisational functions. It is very important that we do not rely on professional bodies to deal with what is organisational malfeasance rather than lack of professional integrity in dealing with individual patients.

My noble friend Lord Hunt made a very important point. It is very strange that at this stage we are still arguing the toss around corporate governance of some of the bodies in the Bill, particularly the clinical commissioning groups. That is a bit of an indictment of the Government for not getting some of this material thought through at an earlier stage rather than well into Report stage in the House of Lords after having gone through the Commons. However, we are where we are and I think we should not tie ourselves up in knots and prevent incumbents.

Lastly, a very important point that has come out in a number of speeches today is that two issues are critical. First, it should be clear legally to all people participating in these new sets of arrangements that declarations of interest are essential. Secondly, it should also be clear in the Bill exactly what the consequences are of not declaring those interests and pursuing deliberately a conflict of interest for your own advancement, financially and otherwise. Those are the two issues about which we need to be clear in the Bill and I rather agree with the noble Baroness, Lady Barker, that much of the rest of it should be for regulation, provided that the Bill has sufficiently powerful regulation-making powers.

Lord Kakkar: My Lords, I too have my name to one of the amendments in this group and would like to reiterate much of what has been said in this very helpful discussion. There is no doubt that there remains considerable anxiety about potential conflict of interest. If, early after enactment of the Bill, the new structures that come into place with regard specifically to clinical commissioning groups were to be attended by serious conflict of interest failings, very rapidly confidence in these new structures would be eroded. That is of very considerable concern.

In Committee, I proposed an amendment suggesting that the Nolan principles be included in this Bill. The Nolan principles are well accepted in public life and play an important role in the conduct of acute and foundation trusts. They have served those organisations well in providing a framework and drawing the attention of those involved in the discharge and governance of those organisations to their obligations with regard

to potential conflicts of interest and their conduct more broadly with regard to execution of public responsibility.

In Committee, the Minister felt that adoption specifically of the Nolan principles was not an appropriate course of action and may have a rather unhelpful limiting effect on more broadly ensuring that conflict was dealt with appropriately. Having listened to debate in your Lordships' House today, it is very clear that considerable anxiety continues. It is important that something is done to ensure that in having taken this Bill forward the Government well recognise the potential for conflict of interest and provide the specific obligations for those who for the first time are going to be directly involved in commissioning and therefore the spending of large amounts of taxpayers' money. Those obligations are in many ways different from acting as a private individual and it will help those discharging these new responsibilities to understand the high standards to which they will inevitably be held and ensure that they discharge those responsibilities for the benefit of the general public and patients.

Earl Howe: My Lords, this has been a very good debate indeed and I thank noble Lords for the careful consideration that they have given to how CCGs should best manage conflicts of interest. I have listened carefully to the various points raised and it is clear that this is an area of key concern. I hope that the House will therefore forgive me if I start by setting out the position on this issue before I turn to the detail of the amendments before us.

At the heart of the Bill is an intention to balance autonomy with accountability. We are giving freedom to those best placed to take decisions in the interests of patients to do so, but we will also hold them to account, not only for the outcomes they achieve but also for their managing this responsibility effectively, transparently and with integrity.

CCGs will be the guardians of significant amounts of taxpayers' money, as the noble Lord, Lord Hunt, rightly pointed out, so it is only right that there are strict requirements in terms of governance, probity and transparency of decision-making. We must balance the benefits of the clinical autonomy of doctors with a robust management of potential or actual conflicts of interest. It is essential to get this right, and that means a proportionate and reasonable approach.

I reinforce the point that the Bill already provides very real safeguards in relation to conflicts of interest. The CCG must make arrangements in its constitution for managing conflicts and ensuring the transparency of its decision-making process. The CCG must have appropriate governance arrangements, including a governing body with lay members and other health professionals. These arrangements will be scrutinised by the

NHS Commissioning Board as part of the process of ensuring that a CCG is fit to be established as a commissioner.

Let me be clear that this is not just about declaring conflicts of interests, which of course is vital, but also about putting in effective and appropriate arrangements to manage these conflicts where they arise. There is not, and cannot be, a one-size-fits-all approach to managing conflict, as it depends on the interest itself and where it may become a conflict. However, likely methods may include absenting the person from decisions in that area, or bringing in others-for example, the independent lay members-to oversee the process for decision-making in a particular area. The key factor here is that they cannot avoid the need to manage the conflict and to be clear about how they are going to do so.

The provisions around conflict of interest apply to all aspects of a CCG's commissioning activity, which means that they would apply to how it worked with a commissioning support organisation. I appreciate that there is apprehension and, in some cases, misunderstanding about the role of commissioning support organisations, so I shall set out the facts about this issue for the benefit of noble Lords today, in particular my noble friend Lady Barker, to whom I was grateful for referencing the brief on this issue provided by Professor Allyson Pollock.

Commissioning support organisations are not intended to act on behalf of a CCG in making decisions. They provide support, which might take the form of analysis of performance or finance data, supporting procurement or the management of a contract, and back-office functions. Let me be clear: at no point can they take decisions for the CCG or assume responsibility for a CCG's statutory duties. It would be unlawful for a CCG to sub-delegate its commissioning responsibility to another organisation.

I am, however, conscious of the concerns, particularly those raised by my noble friend Lady Barker, about whether members of commissioning support organisations could sit on a CCG governing body. I give noble Lords a commitment today that we will prohibit any representative of a commissioning support organisation sitting on a CCG governing body through our secondary legislation-making powers under new Section 14N.

I should also like to explain some of the other safeguards in the Bill relating to management of conflicts of interest. Under Clause 73, the Secretary of State may make regulations which we intend will impose specific requirements in relation to the management of conflicts of interest. They will also confer on Monitor various powers to investigate the actions of a CCG and take remedial action. Monitor will be required to issue guidance on these regulations.

The NHS Commissioning Board may also provide guidance on conflicts of interest. This renders unnecessary any additional amendment requiring the Secretary of State to issue guidance on conflicts of interest, as Amendments 86 and 93 would do, or to issue a specific code of conduct or financial interest rules, as Amendment 38B requires. I shall return to that point in a moment.

The Bill is also clear on the transparency and accountability of the decision-making process. Schedule 2 provides that the CCG constitution must specify arrangements for securing transparency about the decisions of the CCG and governing body. The NHS Commissioning Board will be able to issue guidance on the publication of minutes and will ensure that the constitution meets these requirements. This meets the intention behind Amendment 92. We cannot accept the amendment because it might not always be appropriate to publish details of all decisions made by a governing body.

Transparency and accountability must not be achieved at the expense of the effectiveness of the commissioner. PCTs are not required to discuss all matters in public now and we should ensure that CCGs are not subject to more onerous requirements. Amendment 91 may well prevent CCG governing bodies discussing potentially commercially sensitive issues relating to contract values or performance without the public being present, which could pose difficulties.

I can fully understand the intention behind Amendment 102, tabled by the noble Baroness, Lady Finlay, to ensure that local knowledge informs the work of the CCG. However, we have always maintained that the presence of health professionals on a CCG governing body is not intended to be a means for the CCG to obtain advice to inform its commissioning decisions. The non-GP members of the governing body are there to provide an independent perspective, informed by their expertise and experience, in the body responsible for ensuring that the CCG adheres to the principles of good governance. They must have no conflict of interest in relation to the clinical commissioning group's responsibilities. Amendment 102 would mean that a CCG could have only local professionals in the governing body. This would obviously limit the CCG in its choice of governing body members and risks a conflict of interests. I urge the House not to accept that amendment.

GPs in CCGs have to meet the ethical standards set by the General Medical Council in good medical practice. That includes provision to avoid conflicts of interest. Anyone may raise a concern that a doctor has failed to meet the conditions of their registration with the regulator. However, a failure to meet the conditions which Amendment 93 would impose would not necessarily mean that a GP had been in breach of their conditions of registration, and the duty which Amendment 110 would place on the board would be disproportionate. I know that there is a real concern among some noble Lords and that

it is felt that this is a necessary sanction, but it is far better to ensure the robustness of the approach that CCGs take and that it is appropriately overseen. It is more appropriate for an independent monitor to police the transactional behaviour of CCGs and to be able to take effective remedial action where it discovers evidence that a CCG has not followed regulations in relation to procurement and the management of conflicts of interest, which is the approach taken in the Bill.

I similarly urge that we do not place in legislation an indiscriminate requirement, as Amendments 38B, 93 and 116 would do, that people with an interest withdraw from the relevant decision-making process of the CCG. Clearly, that is often going to be the most appropriate means to manage a conflict of interest, and that is made clear by the NHS Commissioning Board Authority's guidance, *Towards Establishment*, which was published recently. However, it should not lead us to impose on CCGs a blanket ban on individuals being involved in a decision-making process or sitting on the governing body in all circumstances in which they have an interest. It ignores the fine line that can be drawn between situations in which withdrawal is absolutely necessary and those in which it would be more effective for the CCG's exercise of its commissioning function for the conflict to be managed, carefully and with external oversight, in a different way that maintains the integrity of the CCG.

I listened with great care in particular to the speeches of the noble Lords, Lord Warner and Lord Walton, on this theme. The best example of the second category that I mentioned is where a CCG is commissioning for local community-based alternatives to hospital services and it determines that the most effective and appropriate way to secure these is from all local GP providers within its geographic area. There are already inherent safeguards in the legislation to help manage conflicts in this scenario. The CCG would have to declare its commissioning intentions as part of its annual commissioning plan, on which it would consult the public, and it would engage with health and well-being boards in developing; and that makes the proposal transparent. It enables the health and well-being board and others to challenge the proposals. CCGs could similarly secure additional involvement in the decision-making process-for instance, by involving members of the health and well-being board or, indeed, other CCGs or members of the CCG's audit committee. There is a choice. We have not identified one single right way of doing this. We think it is important to allow best practice to evolve rather than trying to pin it down in legislation. If all GP members of the CCG had to withdraw from the decision-making, it would be extremely hard for the CCG to actually make a valid decision, as it could not be delegated to the non-GP members of the governing body or a similar arrangement. It is only in certain circumstances that we would expect individuals with a conflict not to withdraw absolutely, but we have to keep this option open in legislation.

For the same reasons, I cannot support the proposals of the noble Lord, Lord Hunt, and the noble Baroness, Lady Thornton, in Amendment 38B, which would either require a CCG not to contract with a provider in which any member of the CCG had an interest, or require them to secure an exemption from this rule from the NHS Commissioning Board. The conflict and financial interests rules, which this amendment references, already require an individual to withdraw from any part of the decision-making process with a provider in which they have an interest. It is hard to see why it would be necessary also to prevent the CCG from contracting with such a provider or undergo a cumbersome-I have to say cumbersome-exemption process. That approach would make the board have to scrutinise individual procurements and generally police the transactional behaviour of CCGs. It would not allow for alternative local arrangements for quality-assuring the openness and transparency of a CCG's approach. It should not have to be the board only that can ensure the probity of the commissioning decision. As I have suggested, the health and well-being board might provide a suitable external view, as might another CCG.

Lord Hunt of Kings Heath: I am grateful to the noble Earl for giving way so freely. I understand what he is saying about the bureaucratic process. However, will he not accept that the reason for that is that the corporate governance processes around the clinical commissioning group are so weak? For instance, why is there not to be a majority of independently appointed non-execs, as there would be on any other public board?

Earl Howe: I will come to that point in a moment. I do not agree with the noble Lord that the governance arrangements are weak. As I have said, one of the things that the board will have to do when authorising CCGs is to assure itself that there are fit and proper governance procedures in place.

I turn to the question of sanctions, which has been raised by a number of noble Lords. It is essential that patients and clinicians remain confident that members of clinical commissioning groups will always put their duty to patients before any personal financial interest. It is important that CCGs take all possible steps to avoid conflicts of interest. We foresee that the guidance that Amendment 79A requires the board to produce would set out the need for CCGs to make clear in their conflict of interest policy that any member of a CCG found to have failed to declare an interest may face a number of possible sanctions and individuals may also be referred to their professional body, which is a serious matter. The noble Lord, Lord Walton, was quite right in all that he said. I am very drawn to the provision of Amendment 79A, and I will come on to that more fully in a moment.

When there is any breach of the provisions in proposed new Section 14NA, the board would have a range of powers to intervene. The GMC is currently updating its advice to doctors about how they will be expected to exercise their professional responsibilities within the new structure of CCGs. The board's guidance we expect to be consistent with the profession's own high standards.

Amendment 38B would also give the Secretary of State the role of appointing an adjudicator with a range of sanctions, including suspension or removal of a person from being a member of a CCG for up to 10 years. Such a sanction could of course result in the patients of the GP so removed not having their interests represented in the decision-making of the CCG. That would strike at the heart of the principle of clinical commissioning. There is already in the Bill provision for independent scrutiny of the behaviour of CCGs in relation to procurements by Monitor, as I have mentioned. The Secretary of State' regulations will give Monitor the power to investigate commissioning behaviour and, if necessary, take a range of remedial actions, including rendering a contract ineffective.

I do not want noble Lords to be in any doubt as to how seriously we take ensuring the integrity of clinical commissioning, or that we have not considered carefully their concerns. So while I cannot support most of the amendments in this group as they stand, I am supportive of elements of some of them. I am persuaded of the necessity to have a register of interests, placing the CCG under a duty to ensure that interests are declared in a timely manner, and that the CCG acts on those declarations. I am therefore persuaded to accept the amendments tabled by my noble friend Lady Barker, Amendments 79A, 82A, 86A and 86B. I see those amendments as absolutely consistent with the guidance towards the establishment, as I mentioned a moment ago. In my judgment, they would provide the best additional safeguards to those in the Bill. The amendments will deliver much of what is proposed by other amendments, in the most effective way, and I hope and trust that they will therefore receive support from across the House.

I add for reassurance that in placing a new duty on the board to issue guidance on conflicts, the board can build towards establishment and set out unequivocally the expectations of CCGs in how they should manage conflicts of interest and hold CCGs to account. I would also expect the guidance to reinforce the existing GMC guidelines, making clear to CCG members their accountability to the board and the GMC. A number of amendments call for new guidance or codes of conduct. I think that allowing the board to issue statutory guidance in that respect will deliver the intentions of those amendments.

As a consequence of my support for the amendments tabled by my noble friend, I do not intend to move the four government amendments in this group, Amendments 83, 85, 88 and 90, because they will be superseded.

I hope that I have said enough to reassure the House that the Government have acknowledged the concerns on these issues around conflicts of interest. We have listened to the concerns and are willing to amend the Bill accordingly.

Lord Hunt of Kings Heath: My Lords, I think that that is a very disappointing response. The noble Earl, Lord Howe, said that clinical commissioning groups will balance autonomy with accountability, and he acknowledged that they will be guardians of billions of pounds of taxpayer's money. He went on to say that there were three safeguards: the constitution, transparency and the governing bodies. However, he still fails to respond to the fundamental gap, which is the lack of proper corporate governance around clinical commissioning groups. Looking at other public sector bodies-NHS trusts, for instance; not foundation trusts, but NHS trusts-how would we feel if the Government came forward with proposals stating that the board of an NHS trust would consist of executive directors and one or two lay members? It is just possible-but it is not certain-that one of those lay members will be the chairman of the trust, or they could, indeed, be the chief executive. That, in essence, is what the Government are proposing for the governance of clinical commissioning groups. A group of GPs will sit round the table. They will have a couple of lay members who presumably will be appointed by the clinical commissioning group, because the Government consistently fail to say whether there will be an independent appointments process. The noble Earl never responds to me on this point. They will be deciding how billions of pounds should be spent. The noble Earl refuses to acknowledge that these GPs are business people who run businesses which depend mainly on contracts-

Earl Howe: My Lords, I realise that I did not answer the noble Lord and I apologise to him. It may be helpful for him to know that we intend to work with patient and professional groups and with emerging clinical commissioning groups to determine the best arrangements for appointing members of governing bodies. We will be issuing regulations in due course setting out in more detail the requirements for appointing clinical-that is to say, non-GP-members to the governing body.

The report that we had from the NHS Future Forum stated that it would be unhelpful for clinical commissioning groups' governing bodies to be representative of every group under the sun. We agreed with that. Requiring a bigger group of professionals on the governing body itself, or expanding it in any way at all, would not really mean that a broader range of interests are involved in designing patient services. It would just lead to governing bodies that are too large and slow to do their job well. However, we think

that it is important for clinical commissioning groups to be led clinically. That is the point.

Lord Hunt of Kings Heath: My Lords, I am grateful to the noble Earl. However, that ultimately means that a majority of the people on the board of a clinical commissioning group will potentially be able to take advantage of the commissioning decisions of that group. That is why the corporate governance is so concerning. I accept that my amendment might be regarded as rather lengthy. However, I am pushing this forward because I am trying to replace the lack of effective corporate governance.

The noble Earl says that sanctions will be contained in guidance, but I do not think that that is sufficient. The potential for conflicts of interest are so great and the amount of public money involved so considerable that we should have in the Bill a clear commitment to sanctions. I do not agree with the noble Earl that this is something that can be left to professional bodies. My noble friend Lord Warner was absolutely right to mention that case. It shows some of the risks of what essentially was, in that person's case, a managerial issue being pursued by a regulatory body. I do not think that that is the right way of dealing with GPs who, it was alleged, had pursued actions in breach of whatever guidance was issued.

Earl Howe: The noble Lord should not forget what I said about Monitor's powers to look at improper conduct at the CCG level.

Lord Hunt of Kings Heath: My Lords, I am sure that Monitor will play an extremely useful role, but surely it would be much better to give further and clear guarantees that these matters will be dealt with effectively. I believe that we need more provision in the Bill specifically on sanctions. I should like to test the opinion of the House.

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Amendment 38C

Moved by ***Lord Warner***

38C: After Clause 19, insert the following new Clause-

"Integration of services

(1) In discharging any duties under this Act, or any related regulations or guidance, "integration" means the integration of health and social care commissioning, assessment, service provision or payment arrangements with the primary purpose of improving the delivery of integrated care and treatment to individual patients or service users or groups of such individuals.

(2) Annual reports produced in accordance with this Act by the National Commissioning Board; and a clinical commissioning group shall report progress made by that body on improving the delivery of integrated care and treatment in accordance with this definition.

(3) The National Commissioning Board's annual business plan must explain how it proposes to improve integration of services in accordance with this definition.

(4) In developing tariffs, both the National Commissioning Board and Monitor shall have regard to improving integrated care and treatment in accordance with this definition."

Lord Warner: My Lords, I shall speak also to Amendment 143.

A noble Lord: Not before time.

Lord Warner: Better late than never, my Lords. This brings us back to the issue of integration that we discussed in Committee. Since those discussions, which themselves followed the report of the Future Forum, we have had two important and relevant reports from the Commons Health Select Committee, one on public expenditure and one on social care. There was also a robust report in January by the King's Fund and the Nuffield Trust for the Department of Health and the Future Forum on the case for moving forward with greater pace on integrated care. It is clear to me and my fellow signatories to these amendments that it would be a mistake not to use this Bill to provide some stronger requirements and make it more likely that integration of services to benefit patients will actually happen. None of us believes that legislation on its own will deliver integration, but providing a stronger legislative framework is more likely to make it happen. That is the purpose of these amendments.

Let me remind the House what the three reports that I have mentioned actually said. The King's Fund and the Nuffield Trust said that the Department of Health and the NHS Commissioning Board should,

> "develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations".

The report went on to say that they should set,

> "a clear, ambitious and measurable goal linked to the individual's experiences of integrated care that must be delivered by a defined date".

In its January report on public expenditure the all-party Health Select Committee, with a Conservative chair, said on page 32, at paragraph 13, that it,

> "found precious little evidence of the urgency which it believes this issue"-that is, integration-"demands-on both quality and efficiency grounds".

The committee called on,

> "the Government and local authorities to set out how they intend to translate this aspiration for greater service integration into the reality of patient experience".

In its further report on 6 February on social care, the Health Select Committee made clear that the key to joined-up services is joint commissioning. It recommended that the Government should place a duty on clinical commissioning groups and local councils to create a single commissioning process. Its main focus is on integrating services for older

people, but much of what it says applies to a wider group of people. It also draws attention to the difficulty of defining the boundary between the NHS and local authority services.

This is the context in which I believe that we need to strengthen this Bill while it is still before us. It would be a missed opportunity not to do so. We must tackle this issue of the definition of integration, but make sure that it is not limited to particular groups of patients and service users, and that it is not simply restricted to those who straddle the NHS and social care boundary. Those depending solely on NHS services need improved integration, as I have discovered from some of my family episodes and circumstances. We also need not just integration of commissioning, important though that is and on which I fully support the Select Committee's recommendation. Organisational integration is not sufficient, as history has shown us. The definition of integration has to make clear that the primary purpose of the organisational and process changes for integration is to bring benefit to patients and service users through the delivery of integrated care and treatment. As the *Oxford English Dictionary* makes clear, "integration" is:

"The making up or composition of the whole by adding together or combining the separate parts or elements".

If we are to progress service integration for individuals, we need to put a clear definition of integration and its purpose in this Bill. That is what proposed new subsection (1) in Amendment 38C does, in a way that supports the conclusions of the Health Select Committee. The three other subsections ensure that there is no escape for any of the actors in this drama from taking seriously the issue of service integration. Subsection (2) requires that annual reports provided by the Commissioning Board and clinical commissioning groups, under the terms of this Bill, should report progress on improving the delivery of integrated care and treatment in accordance with the definition in proposed new subsection (1). The NHS Commissioning Board is required by the Bill to produce an annual business plan. Proposed new subsection (3) requires that plan to explain how the board,

> "proposes to improve integration of services in accordance with",

the definition in proposed new subsection (1).

Proposed new subsection (4) requires the Commissioning Board and Monitor to have regard to integration of services in the setting of tariffs, which should encourage tariffs that move away from hospital episodes of care to ones that support integrated pathways of care over periods of time.

I turn briefly to Amendment 143, which completes the picture by requiring the Secretary of State's annual report to cover not only the performance of the NHS but its integrated working with adult social care.

I do not claim that these amendments will, on their own, deliver the integrated care that we all want to see, and which the three reports that I have mentioned and the Future Forum are trying to drive. However, they strongly support that drive and put the Bill in a better shape to make greater integration of services more likely. I hope the Minister will see them as a constructive way forward that supports the Government's policy and that he will be able to accept them. If he wants to go further and produce his own amendments to support the Select Committee's recommendations on joint commissioning by placing duties on clinical commissioning groups and local councils, I for one would be glad to give him my full support. I suspect that many people across the Benches in this House would follow that. I beg to move.

Lord Patel: My Lords, I have put my name to Amendments 38C and 143 and support them very strongly. They cover the issues that we raised in Committee and which need to be addressed.

The Government's intention in the Bill is clearly stated: they want to see better quality of care and outcomes, particularly for patients with long-term conditions. I spoke at length about this in Committee and will not repeat myself. However, in brief, a patient who suffers from a long-term condition will get better care and outcomes only if that care is individualised and integrated from primary care, through acute care to community care. If we are to do this, we need some guidance in the Bill itself as to who will be responsible, how it will be done, who will give the guidance and how it will be monitored. I do not mean by Monitor, but how whether it is happening will be monitored. It is for this reason, if no other, that I strongly support these amendments. I agree with my friend, the noble Lord, Lord Warner, about hoping that the Minister will be able to accept these amendments or the principles behind them; and, if he cannot accept them, that the Government support them by tabling their own amendments at a later stage.

Baroness Pitkeathley: My Lords, I, too, will speak strongly in support of these amendments, to which I have added my name. In spite of my major misgivings about the content of the Bill when it was originally published, I remember being delighted by its title because it had "social care" up there with "health". Did this mean, I thought to myself, that at long last health and social care were to be given equal status? At long last, was there to be a proper recognition that the patient experience of being ill, disabled or in need of care is an integrated one? The Bill was supposed to be about

making the patient experience better-less confusing, and more effective and efficient from the point of view of the patient-so I was hopeful.

In more than 40 years of working at the margins of health and social care, I have seen two experiences constantly repeated. The first is of patients always being surprised, distressed and horrified by the lack of integration between health and social care. Since they cannot put their own needs into two separate boxes, they are surprised that the services seem to be provided in separate boxes. They are further distressed by having constantly to give their details and history to different people, having to undergo unnecessary repeat tests and yet still being left alone or reliant on their families to negotiate between the NHS, social care agencies and local authorities, not to mention voluntary and private sector providers.

The second experience which has been constant in my life is the seeming commitment of all those who work in the system to how important integration is to the delivery of proper patient-centred care. Indeed has anyone in your Lordships' House or anywhere else ever heard any professional say that there are benefits to care which is not integrated? Yet that is what we continue to deliver and there seems little hope of the Bill in its current form rectifying and ensuring a joined-up approach. Indeed, I fear for the practice manager or the social worker who has to interpret the new diagrams of the system to an elderly and confused patient or client.

My noble friend quoted the Health Select Committee, which said:

"Although the Government has 'signed up' to the idea of integration, little action has taken place to date. The Committee does not believe the proposals in the Health and Social Care Bill will simplify the process".

The committee further said that the reforms in the Bill were built on the hope that GPs, hospitals and local authorities will respond to payments for working together.

These amendments are about more than hoping for the best. They make practical proposals, first, about defining integration which, as the Law Commission found, is not easy. It will surely not be difficult to agree, as the Law Commission did, around contributing to or promoting the well-being of the individual. That would cover not only health and social care but housing too. That separation, as your Lordships are well aware, has always been a problem.

The proposals about annual reporting and business planning to check progress are also very practical and taking into account the levels of integration in setting tariffs is also very important. It is of the utmost importance that we take the opportunity given by the

Bill to move the reality of integration forward in a way which will make a radical difference. The benefits to the patient, the client and the carer are obvious but there are benefits to the community and society which are similarly significant, since integration clearly delivers more effective and efficient care. There is lots of research evidence about this. For example, Turning Point identified that for every £1 spent on integrating health, housing and social care, £2.65 was saved. This is not only better for patients but provides better value for money. What is not to like in these amendments? I hope the Government will accept them.

Lord Mawhinney: My Lords, it would be very courageous for anyone in your Lordships' House to argue that there was no benefit to the patient in trying to have as integrated a service as possible. I am not that courageous. It is a good place to start. Having said that, I do not believe that these amendments are the answer or that they move forward the argument for integration. I searched through these proposed new clauses and I find no mention of any legal responsibility on the local authority, the social care agencies or anyone else. They are entirely directed to health bodies. That imbalance struck me as being a pretty poor starting point if you are genuinely interested in trying to produce integrated services.

Your Lordships will know that, even before the introduction of the Bill, there were various attempts to integrate services in various parts of the country. I happen to be a reasonably well-informed individual in respect of one of those attempts. It is one thing to say to the PCT, the cluster, or whatever is the latest development in that area that it has responsibilities to integrate with the local authority, just as it will be a different thing to say that a local commissioning group has to integrate with the local authority if some attempt is being made legally to define the role of the health component but there is no commensurate attempt to deal with the legal framework with regard to the providers of social care. I know of one example of attempted integration in this country that is foundering because the health component is seeking to shift its deficit on to the local authority. Sometimes the quality of those who serve in one is so different from the quality of those who serve in the other that no right-minded person who was dealing with his or her own money would invest in a partnership that was as skewed as those that exist up and down the country.

I started where I did because I do not wish to be interpreted as being against useful, appropriate and constructive forms of integrated provision. I have taken a view throughout the Bill that it ought to be for the benefit of the patient. It would be courageous to suggest that some appropriate form of integration would not be of benefit to the patient. However, these skewed and flawed amendments are not helpful and certainly do not beat a path to the future for the benefit of patients.

Baroness Young of Old Scone: My Lords, I rise to support Amendment 38C and to disagree violently with the noble Lord, Lord Mawhinney. I think that the importance of integration applies not just between health and social care but also within health services. We have to start somewhere, and the Bill before us gives us the opportunity-now, today-to start with the important new bodies that will come into existence on the health service side of the partnership. It is fundamental and vital that they are properly tasked with responsibility for integration. Let me explain why.

I hope that many noble Lords listened last week to the interesting and powerful "File on 4" programme on the dreadful condition, in terms of lack of integration, of our diabetes services. Diabetes is a long-term condition and those who have it require each year that about 15 essential and different services are clustered around them in an integrated way; otherwise they run a high risk of suffering premature death or horrific and expensive complications. I emphasise the word expensive because those complications can include kidney failure, blindness and amputation, which are hugely expensive for the National Health Service to treat and could, at the current rate of increase in diabetes, financially wreck the NHS. I hope that at least some noble Lords heard that programme because it demonstrated that integration between health and social care and within healthcare is vital for long-term conditions-not just for diabetes but for other long-term conditions as well.

This is a disputed figure, but it is thought that long-term conditions now take up somewhere between 60 and 70 per cent of the NHS budget. If the Bill is about the future provision of healthcare in this country and how healthcare needs to be joined up internally and with social care, it will have to address that 60 or 70 per cent of NHS expenditure that relates to long-term conditions. Therefore, it is pretty important that the new institutions of the NHS Commissioning Board, the clinical commissioning groups and Monitor are clearly now tasked-while we have the opportunity to influence them-with incorporating integration into their annual plans and with reporting annually on how they have got on with fulfilling this obligation and important duty. I do not think it is too much to ask; I think it is pretty important. I hope the Minister will agree.

Monitor will also have a crucial role in the development of tariffs. At the moment we have tariffs which, unless properly constructed, get in the way of integration: they form a barrier to putting together sensible packages of services. In a competitive environment, that will be even more so. It is fundamental that tariffs are constructed in a way that supports the important integration-and I am not going to apologise for repeating this-which if not delivered results in premature deaths and horrific complications. I hope that the Minister will take this point and support the amendment.

Baroness Wall of New Barnet: My Lords, I, too, support the amendment. I want to focus particularly on integration in terms of what is provided by an acute hospital, compared with what is provided in the community. The noble Earl will know how many times I have spoken about how important and welcome it is that-as my noble friend Lady Pitkeathley said-the Bill includes social care and the patient pathway. However, the patient pathway does not and will not happen for the very reasons that this amendment identifies. It does not happen because of the integration described in the patient pathway, all parts of which patients are attached to, and all parts of which the providers of care try to work to. It will not happen unless the commissioners ensure two things. First, the tariff must make it happen. A tariff must be developed which says that this should be done somewhere else and we must say what the tariff measurement will be. Secondly, they must account for it. We know that while very often commissioners-certainly in the clusters that I am involved with in north-central London-try hard to prevent patients from going to hospital and to prevent repeat visits to hospital, in reality it does not work.

I am very supportive of this part of this Bill, and very keen on the integrated elements, not just with the local authorities-as has been said-but also within the health provision itself, because it is not happening now. These amendments address just that. Can we please hear from the Minister that he understands that the only way for people to be treated nearer to home is by addressing what the tariff is and how we measure it, as well as through accountability of both of the Commissioning Board and Monitor to ensure that this happens? Even in well intentioned trusts, it does not happen because there is nothing in place to make it happen.

Lord Sutherland of Houndwood: My Lords, I support the amendment for three reasons. First, were it to be implemented, the effectiveness of the care provided would be magnified and significantly improved for every individual involved. Secondly, there would be better value for money. Whether we like it or not, the two professions fight with each other over budget: that is the reality. Unless they are pushed towards talking to each other seriously-which this amendment does-that will continue, and we will have the consequence of expensive hospital care militating against the provision of adequate home care. Thirdly, human beings are individuals. Over time especially, they have a number of ailments that need to be seen together, and they need to be treated as individuals. An individual does not break up into bits, going to one institution for part of his or her care and to a second institution for another part. There is a real difficulty here. Previous research shows very clearly that trying to put a dividing line between health and social care does not work.

We hear statements implying that it is going to be really quite difficult. This is not rocket science. It must be based on two professions coming together. This is being done in Scotland at the moment, and they have found ways to move ahead. I understand that there are pilots going on in England at the moment sponsored by the department, and I look forward with great interest to seeing what comes out of these. However, there is a lacuna in the Bill regarding how health and social care integrate. As long as this is so, the amendment would push things forward significantly.

Lord Turnberg: My Lords, we have heard that integrated care means different things to different people. As far these amendments are concerned-including the one to which my name is attached-the focus is on the integration of hospital care, NHS care and social care. Almost since its inception, the biggest problem for the NHS has been the division between health and social services; the division between funding-which of course drives everything-and management.

Acute services have always been the focus of most NHS funding. One might expect me to say, as a former acute care physician, that that is entirely appropriate. However, it has always been clear that this division, with different funding streams, has led to dreadful miscommunication between two sets of staff working under quite different systems, who fail to talk to each other in anything like a timely manner.

The end result is well rehearsed. Patients who would have been much better cared for at home-or in a nursing home if one were available and if someone could have made a proper assessment-finish up in an acute hospital which is poorly designed to provide the sort of care that they really need. On the other side, patients-usually elderly-are admitted to hospital for entirely appropriate reasons, but linger there well after their acute need has been sorted out. Clearly, if we had common funding of health and social services, we could see people employed across this divide. That is what we need: people with a foot in both camps. I take the point made by the noble Lord, Lord Mawhinney, that it takes two to tango-it takes both the heath service and local authorities, and they do not tango terribly well. While we do not have common funding, however, at least we can work towards it. Here we have an opportunity to emphasise the duty that should be placed on the NHS, for one, to ensure integration at this level. This is of such importance for patients that we should emphasise it at the least in this relatively minor way here.

Lord Newton of Braintree: My Lords, I support-with some trepidation-what my noble friend Lord Mawhinney has said, and I pick up the point about it taking two to tango. I yield to nobody in my support for integrated services. I heard what the noble Baroness, Lady Young-a person with whom I go back a long way-said about diabetes, and I do not disagree with it. I do not disagree with what the noble Baroness, Lady Pitkeathley-with whom I go back even further I think-said, presumably arising from her experience as

part of Age Concern. The question is whether this amendment does it, or whether in fact it contains things which will make it more difficult. As the noble Lord, Lord Turnberg, said, it takes two to tango. As I read it, every responsibility here is laid on health service bodies, not local authority or social service bodies. If we are to go down this sort of path, we need to lay equal obligations on both.

However, the issue goes beyond that. It should be recognised that one of the most difficult or most needy areas in this field is mental health, which I know something about even though I no longer have a direct interest. With mental health there is a need for co-operation not just between the various statutory authorities-indeed, many mental health trusts are partnership trusts with the local social services department and have made significant progress, as was true of the one with which I was involved until January-but with voluntary organisations. Where are they covered in all this? I had a difficult case in a mental health trust that I chaired 10 or 15 years ago. Nobody in any statutory service, whether local authority or health, had known that the patient in question was undergoing anger management courses paid for privately, and that caused problems. Last weekend, I was talking to someone in Braintree who is interested in the Rethink Mental Illness charity and is trying to build up the local Rethink art therapy classes, for which he thinks he has acquired a building. That, too, ought to be integrated with the services provided by the mainstream.

I do not believe that this amendment, however valuable it is and however worthy its objective, will achieve that objective without a great deal more sophistication. Personally I would rather leave it to the Minister and his department to issue guidance and apply pressure in rather different ways to produce the integration that we all want. At any rate, I look forward to what the Minister has to say. He may draw more encouragement than usual from some of my remarks and I might even vote with him if it comes to that.

Lord Warner: Before the noble Lord sits down, perhaps I may ask him and his noble friend behind him whether they have seen Amendment 161A, which would introduce a new clause on standards of adult social care.

Baroness Northover: My Lords, perhaps I may remind noble Lords that we are at Report stage. According to my note, only the mover of an amendment or the Lord in charge of the Bill can interrupt with short questions.

Lord Warner: I am the mover of the amendment and I was interrupting with a short question to the noble Lords, who seem to be unaware of a part of the Bill which addresses their concern. Before I was interrupted, I was going to ask them whether they had seen Amendment 161A, which says that the duty would enable the Secretary of State to address the issue of reducing,

"barriers to the delivery of integrated health and adult social care",

and give him powers to produce regulations to deal with that. Therefore, we will be coming to an amendment which, if agreed, will enable their concerns to be addressed.

Lord Newton of Braintree: Perhaps I may respond to the noble Lord from a sedentary position. I was aware of that but, to be honest, I think that we need a coherent single approach.

Baroness Armstrong of Hill Top: My Lords, this debate has been very interesting. I agree with the last comment of the noble Lord, Lord Newton: we need an integrated approach. I support the amendment but I do so with deep frustration. The truth is that the Bill is inadequate and contradictory, and it starts from the wrong place. What everybody wants from the Bill is an answer to the question, "How do we reform the National Health Service now to deal with the starkest view that is facing us in terms of increased numbers of people with long-term conditions?". The past success of the health service is now keeping many more people alive and many of them will have long-term conditions for much longer. That is the single thing with which the National Health Service is going to have to deal with much more skill and integration than ever before, but the Bill makes it very difficult to do that. The noble Lords, Lord Mawhinney and Lord Newton, have made that point for us, so I shall not go on with it. We need a Bill which understands where the National Health Service needs to go and what we need to do to reform our services so that patients get the very best outcome in the most cost-effective way, given what is and will be going on in our economy for a long time to come. However, this chaotic Bill will not do that.

Baroness Jolly: My Lords, I shall not repeat the many arguments that have been eloquently put this afternoon but it is just worth reflecting, as several noble Lords have already done, that integration is not new. Pooled budgets are not new. Torbay has tried to look at integration as a whole-system approach. My noble friend Lord Newton spoke about mental health integration, which occurs for some conditions in some areas. Therefore, integration is not new. The evidence that it is hugely beneficial is legion. That fact is evidence-based. Not only is integrated working better for people but it makes them better quicker and more effectively. However, integration is not universal. When I read through the Bill, I, like the noble Baroness, Lady Pitkeathley, was delighted to see that there was a duty on both the board and clinical commissioning groups to promote integration. That is good news but in a sense we are trying to use legislation to change culture. That is what it is all about. We have spoken about cultural change, and we have to put together two organisations that are not well used to working together. They jolly well should be but they are not. Therefore, we welcome what is in the Bill, although clearly more needs to be done.

I am quite surprised that the areas highlighted in the amendment would not form part of a regular reporting system, which is what is being called for. We would expect the board to take a lead on the mandate and the business plan. I should have thought that the board, the clinical commissioning groups and the Secretary of State would be expected to report on the status and progress of integration across the whole system. I should be very interested to hear from the Minister how this is expected to happen. Will he indicate how the reporting would function on an annual basis and whether the mandate and annual plan would be used in the way suggested in the amendment?

Lord Owen: My Lords, I rise to speak because I am a little troubled. It looks as though the Minister will object to this amendment. Of course, we are speaking in advance of knowing what he is going to do but I should like to give two or three reasons why I very much hope that he accepts the amendment.

First, using the term "social care" in the Bill means that expectations will rise. Those expectations have not been fulfilled and, to be honest, they could not have been. Nevertheless, it was a good idea to try to point to the fact that this was about more than NHS care or healthcare. We all know-it has been said many times in our debates-that there is no way that we can look at the narrow definition of the health service; it has to be broader.

The other powerful argument which I thought the noble Baroness was going to make is that this is a cultural change, and that needs to be re-emphasised at every stage as part of an educative process. Let us take the national Commissioning Board. This is a new body and the person who has been appointed to chair it is an academic lawyer-a person of great distinction. I am not objecting to the fact that it may be somebody with not very long experience of the health service. Nevertheless, a lot of hopes are vested in that Commissioning Board and to draw attention to it in a more declaratory way in this Bill is very important. It needs to know and see in clear terms in the Bill that this is part of its remit. I take great notice of what has been said about the reluctance of local authorities to respond to this. Were we having a debate involving local authority services, I would raise that, too. For a very long time I have believed that in the 1948 Act a great mistake was made in not pooling together local authority health services and welfare and social services in a comprehensive package. As everybody knows, there was a very deep debate inside the then Labour Government between Herbert Morrison and Aneurin Bevan.

There is also another debate about decentralisation and centralisation. That has been with us all these years. In the very early 1960s I wrote a book about a unified health service. When I was a Minister, there was a great deal of animosity within the medical profession at the thought of working closely with local authorities. It is amazing how

that has changed. There is now a readiness in the medical profession in particular-nurses have always done it-to work across these things. I shall make no more points, but I hope that the Minister will accept this amendment. With all the reservations that have been put down, nobody should believe that this legislation will have a very big impact on social care anyhow, but pointing it in the right direction at this moment would be helpful.

Baroness Hollins: The amendments have particular relevance to mental health and learning disability services. In speaking in this debate, I declare an interest as a past president of the Royal College of Psychiatrists. I shall focus my comments on commissioning integrated care.

I remember that in the early 1980s, when I was newly a consultant, we had jointly commissioned services. They worked effectively and provided a very accessible way of developing integrated services. I shall talk briefly about the work that the Royal College of Psychiatrists has already done to support integrated commissioning since the Bill was first mooted. The joint commissioning panel on mental health was launched in April 2011. It is led by the Royal College of Psychiatrists and the Royal College of General Practitioners. It is a collaboration of 15 other leading organisations, service users and carers with an interest in mental health, learning disabilities and well-being across health and social care. It draws on expertise from across the statutory, voluntary and private sectors.

It has already produced guides on primary mental health care and liaison mental health services, which is relevant to the comments of my noble friend Lady Young about integrated care for people with diabetes. My interest here is integrating mental health care into the diabetes pathway. The panel is working on both commissioning guidance: on what is needed; and on practical commissioning tools-how to do it. The practical how-to-do-it tools have been developed with strategic health authorities, thus providing important support to the emerging and new NHS structures. They will be ready in 2013.

The joint commissioning panel on mental health is an example of an existing strong and practical partnership, which brings together the whole mental health sector with government to develop and implement integrated high-quality care and interventions. Incidentally, it is hard to understand why professional organisations leading this work were excluded from the Prime Minister's recent summit on implementation, given this real focus on that issue. Mental health can so easily be forgotten along with other complex services when physicians, surgeons and politicians are debating health rather than mental and physical health. I am interested to know the Minister's views on whether this cultural change needs to be in legislation. Some of the experience gained

in jointly commissioning mental health services provides very good learning for services traditionally seen as providing stand-alone health episodes-good learning that could be used to develop integrated services in other areas of healthcare.

The Earl of Listowel: In rising briefly in support of the amendments, I pay tribute to the Government for their contribution in this area already. This is a personal view, but in my experience the best professionals will find a way through against all odds and against the system to work together in partnership to improve outcomes. What the Government have been doing with the social work workforce in terms of raising the threshold of entry to social work, the additional support for newly qualified social workers and the review by Professor Eileen Munro on child and family social workers is a welcome part to this. I hear again and again from people on the front line that an obstacle to integration is continual structural change. When disciplines have stability and can grow together they can learn to work in partnership effectively. Finally, I welcome the building of capacity in the social work workforce, which will assist with the question of better integrated working.

Baroness Howarth of Breckland: My Lords, I want to speak briefly, not having spoken earlier. In answer to a Question from the noble Lord, Lord Walton, earlier in the day, the Minister talked about his great belief in the integration of services. Indeed, he talked about health and social care services in relation to people with neurological diseases. I have no doubt that the Minister and, I am sure, the Government have a great belief in integration. The problem is that it is in the too-difficult box. Whenever we hear discussions about how we will make a start on the problem, there are real questions about how, about when, about the costs, about which particular authority, and so on. We had a demonstration earlier of the way in which different parts of the organisation-the health service and the local authority-can be set against each other in terms of the working together that they need to do.

I declare an interest as I am involved in a number of charities that have a health focus-a large number of very good partnerships of health and social care working together. I shall describe one briefly simply because I think it is helpful to have an example. It is a brain injury unit in Suffolk where the health services and a voluntary organisation with social care works in a pioneering way to ensure that people can return to the community instead of being hospitalised or unable to communicate with their families in any way. That kind of work is going on and I know that there are other pilots up and down the country looking at how financial services can be brought together.

I come back to a point that I was making at the beginning, which is that the too-difficult box means that there is a need to find a place to start. I do not know whether the Minister believes that this amendment, with Amendment 161A-it is important to look at

them together as they give a balance of health and social care-sees them as the way of making a start. If not, I ask him the very pointed question: when will the Government start? Why is this called the Health and Social Care Bill because, as was said previously, expectations were raised enormously in those who receive social care services? In what way will the Government take the whole plan forward? I know that they have promised a Green Paper, a White Paper and to take things forward, but if we do not have a clear picture, the amendment itself will not help. It alone cannot bring about what people have been discussing, which is the culture change.

Those of us who have been involved in these services for 50 years and more-many who have already spoken can, unfortunately, claim that-have lived with these differences. They have had a profound effect on people's lives, as the noble Lord, Lord Sutherland, said. We have experienced them personally because we have had families going through the services, and we have seen them professionally with patient clients. The other thing I rather worry about is the medicalisation of everybody in this because people who want social care do not necessarily want medicalised social care; they want medical care when they need it.

I am really asking the Minister, so I can think about whether I support these amendments: what is the alternative to ensure absolutely that the Government move forward in a proper programme that brings integration in health and social care to the benefit of every individual patient who needs that sort of care?

Baroness Masham of Ilton: My Lords, I would like to ask the movers of the amendment a question just for my own concern. Health is free at the point of delivery so there should be no problem with integration between primary and secondary care. However, this is not the case in social care as there is means testing. How does this affect integration?

Baroness Thornton: My Lords, I am not going to attempt to answer the noble Baroness's question. I shall leave that for my noble friend Lord Warner or the noble Lord, Lord Patel. The noble Lord, Lord Patel, and my noble friends Lord Warner, Lady Pitkeathley and Lord Turnberg made a very good job of introducing these amendments, stressing the importance of joint commissioning, the work of the Health Select Committee in the Commons and its recommendations, and indeed the vital nature of tariff reform. This is a modest but very important amendment that strengthens the Bill.

Every time we meet on Report on this Bill we are in a different world. The world we are in today is not the same one we were in 10 days ago. As we speak, the Royal College of Physicians has decided by a majority of 80 per cent to ballot its members about how

they feel about the Health and Social Care Bill. By my counting that leaves only two royal colleges which have not consulted their membership so far. We all know what the results of the consultations have been, but still we plough on with this Bill.

The remarks of the noble Lords, Lord Mawhinney and Lord Newton, and the noble Baroness, Lady Jolly, together underline the defects of this Bill. Why are we having a debate about integration at this point in the passage of this Bill? It occurred to me that perhaps those debates should have been had before we had the Bill. However, because you cannot achieve everything does not mean that you should not try to achieve something. That is what these amendments do and that is why we on these Benches are very keen to support them. It seems to me that through all the many definitions of integration that we have discussed in this House, the one that is going to have the most effect on budget and finance is in these amendments here before us today. I hope the Minister will accept these amendments because they will improve this Bill.

Earl Howe: My Lords, integration has been a consistent theme throughout our debates on the Bill and the noble Lord, Lord Warner has made a number of highly informed speeches on this topic, as indeed have many in your Lordships' House. The noble Lord, Lord Warner, made a powerful case for taking action for further integration. There is no disagreement between us on this. It is why the Government have already taken a number of steps to do precisely what he is asking and I name a selection only. We have put duties on commissioners to promote integration. We are creating health and well-being boards, bringing together health and social care commissioners and their representatives-one of the main manifestations of joined-up thinking in this Bill. We are strengthening the duties in relation to pooled budgets. We are placing specific duties on Monitor to support integration and tabling an amendment prior to Report giving Monitor express power to do that. We are working with the Future Forum, the King's Fund and the Nuffield Trust in a whole range of non-legislative measures. This is not as the noble Baroness, Lady Howarth, put it, something the Government have put into the "too difficult" box. We are determined that we need to tackle this. I hope no one in your Lordships' House is left in any doubt about our commitment in this area.

There are numerous examples of the non-legislative things we are already doing. We agreed with the Future Forum's recommendations that the board should produce commissioning guidance for CCGs that focuses on how to meet the needs of different groups of people who may have multiple problems such as the frail elderly. By April 2012 the department will put in place new metrics that bring together existing data on patients' experiences at the interface between services. We are working with the NHS Institute for Innovation and Improvement to identify and spread examples of good practice in local measurement and improvement of pathways of care. Through the NHS

operating framework for 2012-13 we are asking all PCTs to work with their local authority partners to look at how integration can be better achieved. I have a whole string of other examples.

As I have said, the commitment of the Government in this area should not be doubted. I was very pleased to see the King's Fund and the Nuffield Trust in their report to the Future Forum recognising that,

> "integrated care lies at the heart of"this Bill,
> "to put patients first, improve health outcomes and empower health professionals".

That is exactly right. While there is clearly work to be done to make this a reality, the Bill will, for the first time, create duties for NHS bodies to promote and encourage the commissioning and provision of integrated services. It is a difficult concept to define. While the noble Lord, Lord Warner, is to be congratulated on the attempt he has made in his amendment, my fear is that the amendment will not actually take us very far. The precise term "integration" is used only in headings in the Bill and the concept of integration is applied in a number of different contexts so a fixed definition of this kind may not be appropriate in every case. It may be too narrow in some cases-some noble Lords have alluded to that point. It is also a somewhat circular definition, referring as it does to integration meaning the delivery of integrated care. That serves to illustrate the real difficulties with this approach.

I am not convinced that it is necessary to try to describe what integration means. Integration is a broad concept. It could encompass a range of measures. As the recent King's Fund and Nuffield Trust report noted,

> "integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs".

Yes that is right and the duty on the board in new Section 13M is absolutely consistent with that approach.

We were very grateful to the Future Forum for its recent work on integrated care. We welcome its recommendation that the entire health and social care system should share a clear and common understanding of the value of integration as a means of putting patients at the centre of their care. However, it was also clear that rather than being an end in itself, integration is,

"a means to achieving better outcomes for people".

That is surely right. There must be the scope for integration to be adaptable to the needs of local communities and individual patients. The noble Lord's definition holds,

"improving the delivery of integrated care and treatment to individual patients"

as the objective in itself when improving outcomes and reducing inequalities should be the ultimate objectives.

Very recently, I was advised of a paper produced by the World Health Organization in 2008, *Integrated Health Services - What and Why?* It starts off by stating that integrated health services mean different things to different people. It lists a whole variety of interpretations of what integrated healthcare means and says that it is in essence very difficult to boil these things down to a definition that is going to please everybody. It also casts doubt-I do not want to make too much of it-on the empirical base for claiming that integration is the answer in every set of circumstances. In making that point, I do not want to imply that the Government are anything other than fully committed to integration, because we certainly are, but the paper's conclusion is:

"'Integration' is used by different people to mean different things. Combined with the fact that this is an issue which arouses strong feelings, there is clearly much scope for misunderstanding and fruitless polarization".

For the World Health Organization to come to that conclusion tells a story. In drafting the various duties and powers in relation to integration, we have consciously avoided a fixed definition to allow for a measure of flexibility and innovative thinking. We have focused on the purpose-the "why" rather than the "how".

I recently met front-line staff when I visited the NHS on the Isle of Wight to look at how they were delivering an efficient, integrated, urgent care service. I made a point of asking them whether they thought that a definition of integration in the Bill would be helpful. I received a resounding no in response. They felt that something like that would stifle their ability to apply fresh thinking and to come up with inventive solutions of their own as to how best to provide integrated care. We are clear that we should not put clinicians, who know the needs of their patients best, in a straitjacket by defining integration in the Bill.

Clearly, it will be important that the board and CCGs are held to account for delivering against these duties. They are already required to set out in their annual reports how

they have exercised their functions, including how they have met the various duties placed on them.

Amendment 38C also makes particular reference to the board and Monitor developing tariffs that will support integration. On that point, I reassure the noble Lord that the duties on the board and Monitor to promote integration would apply in relation to their functions in relation to the tariff. The clauses on the tariff allow a high degree of flexibility for the board to adopt different approaches to tariffs, including "bundles" of services or pathways, and we are committed to extending these. They also allow scope for local flexibility in how the rules are applied where necessary. The noble Baroness, Lady Wall, provided considerable insight into what is needed here. Perhaps it would be helpful if I gave an example of a pathway tariff.

In 2012-13, we are introducing a "year of care" tariff for funding cystic fibrosis services, developed with the support of the Cystic Fibrosis Trust. This includes all the care for cystic fibrosis patients for a whole year. The price is broken down into different "bands", depending on the complexity of the patient. The tariff will cover the care undertaken by specialist centres and local hospitals, but it will be paid only to the specialist centre thereby promoting better joint working between specialist centres and local hospitals. We are confident that the board, with support from Monitor, will continue to develop and increase the scope of bundled service tariffs where it is clear that tariff design of that kind is appropriate and will deliver benefits to the patient.

Under the proposed system, Monitor and the board will have to agree elements of the tariff with each other at all stages. The methodology would be subject to consultation and capable of independent review to ensure transparency and fairness. In addition, under Clause 119, the board and Monitor are specifically required, in developing standard specifications of services for the purposes of the national tariff, to have regard to whether this could have an adverse impact on the provision of services.

I hope that that provides sufficient reassurance to the noble Lord, Lord Warner, that the emphasis on integration is there, but that he will accept that trying to pin down in words what it should look like may be counterproductive. This is not an argument about the Government's commitment to integration or what we are doing on the ground to achieve it; it is an argument about a specific mechanism designed to achieve it. I think that it is a mechanism that is ill-advised. I hope that the noble Lord will agree to withdraw his amendment.

Lord Winston: I have a short question for the Minister because I feel that it is an important issue. Perhaps I may very briefly tell him about something that I learnt of last

week. A friend of mine went to a very famous ENT hospital after a month with a fractured nose-

Noble Lords: Order!

Baroness Northover: My Lords, the Minister has sat down, so it is for the mover of the amendment to respond.

Lord Winston: I am sure that the Minister will want to answer my question because it is not aggressive or political; it is really to find out how this Bill will work. When somebody goes to casualty after a month with a broken nose and complains, "Look, my main problem is the pain in my sinuses which I have had for a long time", and is told by the doctor when they had already waited six hours, "I'm afraid the sinuses are a different department. You'll have to make another appointment", that is a problem with integration. How does the Minister think we might accomplish better integration with this Bill?

Earl Howe: It is a very interesting question from the noble Lord. When I visited Oldham a few weeks ago, I saw for myself how they were getting around that problem in the context of musculoskeletal services. Instead of patients being shunted from pillar to post, they had a system whereby the patient could move seamlessly and immediately from one specialist to another. They did not have to be referred; they could ring up the centre and ask to see a particular person. That is the kind of integrated model that we need to see rolled out more generally in other services. I recognise the issue that the noble Lord raises, but it is one that we are seeing inventive solutions arising to address. I hope that the work being done will do that.

Lord Warner: My Lords, there have been some extremely powerful speeches of support for this amendment for which I am extremely grateful. I am grateful in particular to my co-signatories and I noted the powerful speeches of the noble Lords, Lord Owen and Lord Sutherland, and the noble Baroness, Lady Young. They have made the case for an amendment of this kind to the Bill.

I was disappointed by the Minister's response. That was not just because I got only a B- for my definition-I expected to have my homework marked by officials in the Department of Health and was not expecting to get a high score-but because I think that the definition meets the needs that we have. I find it very difficult to see how the Minister can stand up and say, "Well, we're going hold people to account; we're going to monitor their performance", if we do not have a definition against which we are going to monitor their performance.

The definition proposed by the amendment moves us away from a preoccupation with integration as organisation and process change to delivery of services to the individual. I do not see how the Minister can say, "We're concerned about outcomes for individuals", if we do not integrate delivery. You are highly unlikely, I would say as a jobbing ex-public sector manager, to get good outcomes if you have not orchestrated the delivery of the services to the individual that meets their needs.

Earl Howe: I would not want the noble Lord to believe that I was dismissive of the point that he has just made. I recognise that it is important that we somehow give the meaning of integration a clearer explanation, whether that is through the guidance issued by the board or, indeed, the Explanatory Notes to the Bill. I am just wary of putting something in the Bill. That is all.

Lord Warner: I guess I am more of a risk taker than the noble Earl and I believe that we could put a definition of this kind in the Bill. It would cause no confusion-indeed, it would remove it-in the minds of many people working day in, day out in the NHS. As to those who have asked, "What is the purpose of some of the other changes?", the noble Lord, Lord Owen, powerfully made the point that we need to give strong signals to these new players in the game. We want them to start off knowing that they will be held to account in their annual reports for monitoring their progress on integration. We want that: it is deliberate. We want them to know that Parliament put that in the Bill for a purpose. I am not satisfied with the Government's response and I beg leave to test the opinion of the House.

Division on Amendment 38C

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Clause 20 : Functions of Special Health Authorities

Amendments 39 and 40

Moved by ***Earl Howe***

39: Clause 20, page 15, line 10, at end insert-

"( ) Subsection (1) does not apply to any function of the Secretary of State of making an order or regulations."

40: Clause 20, page 15, line 22, at end insert-

"(6) In section 273 of that Act (further provision about orders and directions), in subsection (4)(b)-

(a) before paragraph (i) insert-

"(zi) section 7 about a function of a person other than the Secretary of State," and

(b) in paragraph (i) after "a function" insert "of the Secretary of State"."

Amendments 39 and 40 agreed.

Clause 22 : The NHS Commissioning Board: further provision

Amendment 41 not moved.

Amendment 42

Moved by ***Lord Warner***

42: Clause 22, page 16, line 22, after "appropriate" insert-

"( ) the priority and scope for commissioning service redesign and reconfiguration in the light of the best clinical advice available,

( ) the priority and scope for transferring resources to adult social services to improve service integration and achieve best value for health services,"

Lord Warner: My Lords, so near, yet so far. Amendment 42 is very simple. It requires the Secretary of State to include in his mandate to the national Commissioning Board the requirement to set out two things. First,

> "the priority and scope for ... service redesign and reconfiguration",in the NHS,
> "in the light of the best clinical advice available",

and secondly,

> "the priority and scope for transferring resources to adult social services to improve service integration and achieve best value for health services".

These are two big issues for the NHS and how it meets the Nicholson challenge of £20 billion of savings by 2015 and how it improves service integration. The proposals in this amendment are very much in line with the recommendations of the Health Select Committee in its two recent reports on public expenditure and social care, which were mentioned on the last group of amendments. As the *Public Expenditure* report said on page 30:

"The Nicholson Challenge can only be achieved through a wide process of service redesign on both a small and large scale".

It went on to say,

> "we are concerned that savings are being made through 'salami-slicing' existing processes instead of rethinking and redesigning the way services are delivered".

Since I put this amendment down, I am pleased to say that the Minister has responded in a most constructive way. On the first part of the amendment, regarding service reconfiguration, he has entered into most constructive discussions on this issue and the related Amendment 217 in my name and the names of the noble Lord, Lord Patel, and the noble Baroness, Lady Williams, regarding a pre-failure regime. The Minister has undertaken to have an alternative to that amendment prepared before Third Reading. I would be glad to hear more today on how that work is progressing.

On the second prong of the amendment, the Minister has had prepared an alternative approach for transferring money from the NHS to adult social care by amending Schedule 4. This gives the Secretary of State power to direct the board to make payments for community services, which, I understand, include adult social care. This is Amendment 148B, in the name of the noble Baroness, Lady Murphy. It would have been in my name as well if I had not been dallying in India when the noble Earl wanted to discuss it with me. I am very supportive of that amendment on the assumption that, as

drafted, it is wide enough to cover adult social care, because that term is not mentioned specifically, and on the assumption that there are no vires issues with the Treasury on the matter of using NHS money for social care. Perhaps the Minister could provide some assurances on this when he responds.

These issues are important for the NHS and for patients in the particular financial and demographic challenges that services face. I am pleased with the Government's constructive response. In the mean time, in order that we may debate these issues, I beg to move Amendment 42.

Baroness Murphy: My Lords, I will interject here with regard to my amendment to Schedule 4, tabled as Amendment 148B in the supplementary hymn sheet.

First of all, I thank the Minister very much for the discussions that I had with him and the Bill team last week. As a result, I tabled this amendment. Unfortunately, I omitted to let the Whips' Office know that it was to be discussed with Amendment 42, otherwise they could have been tabled together.

As I understand it, the important thing about this amendment is that it addresses the issues that we have just spent another hour discussing of how in practice you get money flowing from health to social care, and how you promote integration of services through some practical mechanisms on the ground. Over the last 60 years, there has been too much money held in the NHS-I say this as a health service person-when it should have been better transferred in to social care services to support people with long-term conditions. It has been extremely difficult to get mechanisms that work well. The importance of this is that we do not have to have it repeated in the mandate, which was in the amendment tabled by the noble Lord, Lord Warner. I was very supportive of that, but it is much more flexible to have it as the Secretary of State's direction. It also covers wider organisations than adult social care, although we expect that to be the main route to which the Secretary of State would wish to ask for moneys to be transferred. My amendment is slightly superior in that respect to the amendment proposed by the noble Lord, Lord Warner. However, it does not address the most important issue that the noble Lord brought up in the first part of our amendment-that of the reconfiguration of services and how you can prepare and work towards dealing with issues around failing organisations and services. I know that, as the noble Lord said, the Minister has been looking at that issue and may be able to come back to us with some mechanisms for that-but on this one I wish to speak in support of my Amendment 148B, which addresses the Secretary of State's direction in Schedule 4.

Lord Patel: My Lords, I have added my name under that of the noble Lord, Lord Warner, and I would also have supported Amendment 148B under the name of the noble

Baroness, Lady Murphy, if I had not been in India at the same time-not, I hasten to add, with the noble Lord, Lord Warner.

I merely wish to speak about reconfiguring hospital services. It is quite clear that in the long term demographic changes and the shifting burden of disease require a fundamental shift away from acute care in hospitals to supporting people with long-term conditions in the community. The recent financial pressures and shortages among some parts of the workforce and the need to improve quality and safety mean that changes to hospital services in some parts of the country are already a necessity. The Government have argued that service change should be locally led. In Committee, the Minister stated that,

> "we should be cautious about any process that would significantly weaken both local commissioner autonomy and public engagement".-[*Official Report*, 13/12/11; col. 1271.]

I agree that clinicians and local communities must be fully engaged in the process of service change. However, local involvement and strategic leadership are not mutually exclusive. For example, the reorganisation of the successful stroke services in London proceeded with strong support from clinicians and the public. It is not clear how strategic reconfigurations of specialist services will be led. Again in Committee, the Minister stressed that the NHS Commissioning Board,

> "will be able to support clinical commissioning groups by providing support and advising on the possible effects of larger changes".-[*Official Report*, 22/11/11; col. 1046.]

A recently released paper outlining the design of the NHS Commissioning Board confirmed that involvement in large-scale reconfigurations will be one of the functions of the four regional sectors that will be established as part of the board. But I am not too sure whether the NHS Commissioning Board has the necessary capacity or experience to do that. The lack of clear responsibility for driving forward strategic reconfigurations of services is the most significant omission from the Bill. We need a clearer explanation about how these reconfigurations will be taken forward under the new arrangements, otherwise the risk is that the NHS will not be equipped to meet one of the bigger challenges, as is necessary to reconfigure some of the acute services.

Lord Rea: Would the Minister look at the experiment mentioned by the noble Baroness, Lady Jolly, in Torbay, where there has been considerable merging of health budgets and social services? That was locally led, but would it not have helped to spread it further

with an amendment such as this in place, so that it could be encouraged from the centre?

Baroness Thornton: My Lords, I support these amendments, and I do so because I agree with the noble Lord, Lord Patel, that there was a grave omission from the Bill that would allow strategic reconfigurations to take place that are not based on failing institutions. It was certainly not clear to us-and I rest on the authority of my noble friend Lord Warner on this-how, with the abolition of the SHAs from April 2013, strategic reconfiguration of specialist services would take place. Ministers have said, "Oh no-it's all going to be okay", but they have not explained how you would reconfigure the stroke services in London, as the noble Lord, Lord Patel, said, after the abolition of the strategic health authority. We support the amendments and hope that the Minister will do so as well.

Earl Howe: My Lords, we have had several lively debates on the importance of redesigning services if the NHS is to become more personalised and productive, and the noble Lord, Lord Warner, speaks with great insight and passion on this issue. He has tabled further amendments on this topic, which we will have an opportunity to debate in detail at a later stage.

The Government are clear that, as a basic principle, the reconfiguration of services is a matter for the local NHS and that decisions about service change should be driven by local assessment of need. The reconfiguration of services works best when there is a partnership approach between the NHS, local government and the public. What matters is that strategic decisions are taken at the right level. We believe that our reforms will enable commissioners to make the changes that will deliver real improvements in outcomes for patients and the public. The Bill places clear duties on the Commissioning Board and clinical commissioning groups, which will underpin a locally driven approach to service redesign, clinically based and framed around the needs of patients. That includes duties to promote the NHS constitution and the involvement of patients as well as duties to secure continuous improvement in the quality of services and to reduce inequalities. These duties set important guiding principles against which the commissioning system will develop and oversee service redesign and reconfiguration. In addition, the NHS will continue to assure reconfiguration proposals against the four clear tests set by the Secretary of State, which are that proposals should have support from clinical commissioners; should be based on robust patient and public engagement; should be underpinned by a clear evidence base; and should be consistent with current and prospective plans for patient choice. The Bill and the four tests will ensure that any proposals for service change are based on a thorough assessment of local need, underpinned by clinical insight and developed through dialogue between

commissioners, providers, local authorities, patients and the public. Of course, the board will have an important role in providing support and assurance to local commissioners, but we will not be replicating layers of top-down management.

With the clear legal duties set out in the Bill, the four tests and the support and assurance that will be available, there should be no need for the Secretary of State to prescribe through the mandate how the commissioning system should prioritise and determine the design of services. To do so would cut right across the clinically led local commissioning, which is at the heart of the Bill. Nevertheless, I recognise the importance of getting these arrangements right, and between now and Third Reading I commit to working with the noble Lord with a view to finding a formula designed to address the concerns that he has articulated. We are looking at a range of options. I hope to be able to say more about this when we reach his later amendment on the subject. I hope that for now he will find this rather broad assurance sufficiently strong to enable him to withdraw that part of the amendment.

I hope that the noble Lord will be able to withdraw the rest of Amendment 42 as well, because it also raises another issue. It is vital, especially in the current economic climate, for the NHS to provide financial support for adult social services where possible in relation to those services at the interface between health and social care. Here, I pay tribute to the noble Lord, Lord Warner, who has been a tireless advocate of social care at numerous stages of our proceedings, to ensure that this element of the equation-and that part of the Bill's title-is not overlooked.

The noble Baroness, Lady Murphy, has tabled Amendment 148B with a similar aim in mind. We are all, I think, aware of the impact that such services can have in helping people to live independently in their own homes and in reducing unnecessary hospital admissions-which is, of course, better for the individuals involved and relieves pressures on the NHS. The last spending review included a commitment to provide £648 million in 2011-12, rising to £700 million by 2014-15, for these purposes. Early indications are that this funding has helped to promote integrated working between social care and health commissioners. We want this to continue. I can reassure the noble Lord and the noble Baroness that by virtue of paragraph 130 of Schedule 4 to the Bill the NHS Commissioning Board and CCGs will inherit the powers that primary care trusts currently have under existing legislation to make payments to local authorities towards expenditure on community services.

Generally speaking, our approach in this Bill has been to give NHS commissioners maximum autonomy in how the NHS budget is used. However, I have sympathy for the argument that it is legitimate that the Secretary of State should be able to determine the proportion of NHS funding that is to be transferred to local authority community

services in order to secure closer working between the NHS and social services. I am not sure that the mandate is the right vehicle for this. However, I can see very considerable merit in the approach that the noble Baroness has taken with Amendment 148B. This amendment would give the Secretary of State additional powers to direct the board on the minimum amount that it should transfer to local authorities in a given financial year. The Secretary of State would be able to specify in the directions the bodies to which those payments should be made, the amount that should be paid to each body and the functions in respect of which the payments must be made, and to amend these instructions if necessary. It would essentially enable the current arrangements to continue.

The noble Lord, Lord Warner, asked whether the amendment was wide enough to cover adult social care; whether it was within vires; and whether the Treasury is content. The answer to all those questions is yes. Indeed, I am advised that the amendment would enable funding to be transferred to other community services, such as housing, if necessary.

The approach taken is in line with current practice, which is approved by and agreed with the Treasury. Importantly, this would represent only a minimum. The board would retain the power to make additional payments over and above those required by the Secretary of State if it chose. The CCGs would also retain their powers to make such payments. Although I think it makes sense for it to be the NHS commissioning board that makes these payments, it would also be vital that there is a dialogue between local authorities and clinical commissioning groups as to how the funding could be best used. Of course, both will be involved, as members of health and well-being boards, in setting the strategic framework for health and social care commissioning through the joint health and well-being strategy. In addition, the existing powers in Section 256 for the Secretary of State to give directions on the conditions that should apply to such payments would apply. This is helpful because it would provide a mechanism for ensuring that the agreement of the health and well-being board is obtained as to how funds are spent.

The noble Lord, Lord Warner, has spoken with great conviction about the Bill's importance, including the tangible duties to act to ensure that integration moves from being just an aim to being a reality-as, indeed, the Future Forum has emphasised that it must. I think that Amendment 148B meets all the criteria to ensure that that will be the case. I shall therefore be happy to support it if the noble Baroness should decide to move it. I hope that my noble friends will join me in supporting the amendment; I would urge them to do so. Given that commitment, I hope that the noble Lord, Lord Warner, will be prepared to withdraw Amendment 42.

Lord Warner: My Lords, I am grateful to the Minister for his explanations and reassurances. I certainly think that Amendment 148B is a better amendment than my provision on social care in Amendment 42. I am very happy also to accept his broad assurances that we will have a discussion and dialogue to see whether we can move forward on, in effect, a version of a pre-failure regime, while recognising the Government's commitment to local decision-making on redesigning and reconfiguring services. On that basis, I am happy to withdraw the amendment.

Amendment 42 withdrawn.

Amendment 43 not moved.

Amendment 43A

Moved by ***Lord Kakkar***

43A: Clause 22, page 16, line 25, at end insert-

"( ) The mandate shall also require performance monitoring in primary care by the Board."

Lord Kakkar: The amendments in this group all deal with the question of monitoring performance in primary care. The first amendment deals with the question of the Secretary of State providing, as part of the mandate, clear guidance on performance standards for primary care. The second amendment deals with the NHS Commissioning Board paying due attention to these standards and ensuring that data are collected with regard to performance in primary care. The final amendment deals with the role of clinical commissioning groups, with particular reference to assisting the NHS Commissioning Board in discharging those particular responsibilities.

At the very heart of the Bill is an important and much welcomed understanding that, to deal with the demographic challenges and the change in the nature of clinical practice that our society will face in the coming years, there needs to be a move away from managing patients with chronic diseases in the hospital environment and ensuring that they are managed in the community and primary care environment. This, of course, is welcome and is an important recognition of the changing nature of disease that we will face in terms of delivering good clinical care in achieving the best clinical outcomes.

There is no formal mechanism in the Bill as it currently stands to ensure that data on the performance of primary care practitioners are collected on a regular basis; that there is an absolute obligation, as part of the Secretary of State's mandate, to adopt a clear

primary care outcome framework; that that framework sets clear standards which need to be achieved in primary care; and that data on the achievement of those objectives are collected regularly and transparently to enable patients to understand whether their general practitioners are performing to the highest standard.

This is very important because, in hospital practice, there has been an emphasis on the collection of outcome data for some years, such that audit is an absolute obligation, particularly on those who work in craft specialities and undertake procedures that may be attended by poor outcomes. We also know that in acute services-such as those for patients with acute myocardial infarction and stroke managed in the hospital environment-there is an obligation to collect data on those outcomes, which are increasingly available to other clinical colleagues, to patients and the public. This helps in a broader and fuller understanding of the performance of acute care trusts. However, when it comes to performance in general practice, these data are not routinely available.

As more practice moves to the primary care environment, it will be increasingly important to ensure that when patients are managed for a much broader range of diseases and conditions in that environment, the outcomes achieved by those individual practices are both properly understood and monitored or reported in such a way that if services are commissioned in a primary rather than secondary care environment, those commissioning decisions are taken on the basis of objective outcome data. It is therefore essential that the mandate deals with the question of performance in primary care.

I know that, more broadly, the mandate will deal with the question and the obligation always to strive to improve the quality of care and, implicit in that, to achieve the very best clinical outcomes whatever the care environment. However, as there is now such an emphasis on transferring care out of the hospital and into the primary care environment, we need to be sensitive to what that environment will mean both for a number of practitioners and for their patients.

Unlike the hospital environment, where large numbers of clinicians tend to work together and there is an opportunity for a patient to be reviewed by a number of clinical teams at different stages in the natural history of managing their condition, patients in primary care will often be managed in single-handed or small general practices where they will not have the opportunity to be reviewed by a number of different doctors, including those in training, and where shortcomings in care will often not be understood or recognised by the patients for whom the care is being provided. It is therefore vital that we set high standards in what is expected in primary care and that we ensure that the metrics applied can be measured objectively and that the data are not only collected

as a matter of obligation but reported in such a way that other clinicians and patients can understand them.

If the Bill's purpose is to be fully achieved-to ensure more movement from the secondary and tertiary care sectors into the primary care environment, particularly for the management of chronic diseases-it is essential that these types of data are made available; that the primary care outcomes framework sets specific standards; that there is an obligation to monitoring the achievement of those standards; and to have transparent reporting. It is important for the Government to try to ensure that those objectives are met. One of the safest and surest ways of doing so is to include in the Bill an obligation regarding these functions and obligations. I beg to move.

Lord Patel: My Lords, I support the amendment. I spoke at length in Committee on a similar amendment and my noble friend Lord Kakkar has covered quite extensively why we need some kind of primary care outcomes framework which assesses the performance of primary care. Primary care will be involved in prevention, diagnosis, treatment and long-term care of patients. Hitherto what we have had is QOF, which has already been found to be lacking in identifying the quality outcomes that demonstrate improvement in care. For example, in cardiovascular disease, evidence was presented from 1,000 primary care practice interviews and their performances as assessed did not show that there was improvement through QOF. Of course in certain other areas, there might be. The management of hypertension again shows no improvement. In a study carried out of chronic hypertensive patients, there is still a high incidence of complications related to hypertension. So we need other measures and in the absence of a primary care outcomes framework, we do not know how primary care will be performance managed.

Lord Walton of Detchant: My Lords, I have put my name to two of these amendments so ably proposed by my noble friend Lord Kakkar. I have been on the medical register now for 67 years. I am a registered medical practitioner and I actually have a licence to practise which allows me to prescribe-not that the opportunities of clinical practice in my present world are very widespread, except on the very rare occasions when I have been called upon to minister to one of your Lordships who may have been taken ill in the precincts of this House. The licence to practise will be subject later this year to a process of revalidation.

If I go back to the days-forgive me again-when I was president of the General Medical Council and served on a number of occasions on its conduct committee's hearings, it became perfectly clear that some of the doctors referred to the GMC were not actually guilty of serious professional misconduct. However, some of them who came before the conduct committee were in fact practicing at a standard which was not adequate in a

clinical sense. In other words, there was a question in a number of cases of their clinical competence. In those days the GMC began a process to examine whether, alongside the conduct procedures, we should introduce procedures to be able to identify doctors who were practising at less than an adequate standard of care. In the end, under the noble Lord, Lord Kilpatrick of Kincraig-my successor as president of the GMC-it eventually introduced performance procedures to assess clinical performance. Those performance procedures have continued and have been very effective in identifying and handling appropriately, often with retraining, doctors who were found to be practising at less than an adequate standard of performance.

The Minister may say that when, later this year, doctors will be able to retain their licence to practise subject to a process of full validation of their clinical competence, that may be enough. The fact is that I do not believe it will be, and it is therefore crucial that we have a mechanism in the Bill to deal with this potential issue. After all, over the past 40 or 50 years, there has been a massive improvement in the standard of general medical practice in the UK, following the introduction of compulsory vocational training. Every doctor wishing to be fully capable of being a general practitioner has to undergo, at a minimum, three years' vocational training. The improvement has been immense, but everyone will recognise that not all practices are of such a uniformly high standard. Some doctors in practices may be less competent than others.

The same may be true-who knows?-of clinical commissioning groups. There is clear evidence that most clinical commissioning groups of consortia of GPs will be providing a high standard of care in the community, but there may be a few that are not up to that standard. It is therefore crucial that we have a mechanism whereby the Secretary of State can be in a position, through amendments such as those proposed by my noble friend Lord Kakkar, to identify those practices and clinical commissioning groups that are not producing clinical care of the adequate and appropriate standard which we all expect and which our communities deserve. For this reason, some kind of monitoring of this sort under the mandate is essential.

Lord Rea: My Lords, as a former general practitioner I very much welcome this amendment. As the noble Lord, Lord Walton, has just said, the standard of general practice has certainly gone up enormously since vocational training started. However, a number of my colleagues are not up to scratch. The Royal College of GPs and the BMA would be the first to admit that all in the garden is not lovely. I would ask the proposers of the amendment, and the noble Earl, if he is minded to accept it, how the monitoring system will be set up.

As has been mentioned, there are already two different systems in operation to monitor the standards of clinical practice-in fact three, if we take the GMC competence system.

However, as mentioned by the noble Lord, Lord Patel, QOF is not a very effective measure. Its standards are set far too low. We have yet to see whether revalidation will effectively identify weak practice. If this monitoring is going to be set up, would it not be sensible to involve the General Medical Council, the Royal College of GPs and the BMA in consultation in designing the performance monitoring system that will be adopted? It could be a very good idea. It is high time that there was a more effective system. Most GPs would welcome it enormously and only a few would regret it.

Baroness Finlay of Llandaff: My Lords, I would like very briefly to speak in support of these amendments and ensure that we do not confound QOF, revalidation and the principle of these amendments. They are three different things. The principle behind the amendment is really important because it will identify the range of practices. There was an interesting paper in *The Lancet Oncology* this week showing the variation in the number of times patients have attended a GP before diagnosis of some cancers like lung, pancreas and so on, whereas those where there has been much greater publicity, such as breast and melanoma, have been referred much more quickly and there is less variation.

Revalidation is about making sure that people are, in the broadest sense, safe to practise and it is hoped that it will filter out those who are really unsafe across the board. However, that is not just what we are talking about with these amendments. We are talking about trying to improve the spectrum of care, including care by those who will get revalidation and who may well be collecting QOF points, but to whom other clinicians in the area would not necessarily want to sign up as patients. So it is about driving up those lower standards to meet the higher standards that we expect. Those data in the public domain will be really important to help patients decide who they register with. I hope, therefore, that the Government will look favourably on the amendments. The amendments are coming from those of us on these Benches who are medically qualified. I should declare an interest as a fellow of the Royal College of General Practitioners.

Lord Hunt of Kings Heath: My Lords, I would like to echo my noble friend Lord Rea and noble Lords from the Cross Benches on the importance of this group of amendments. At its best, primary care can be brilliant, but at its worst it can be absolutely appalling. The variation in primary care is probably wider than in any other part of the National Health Service. As the changes take place we can see that this may cause many problems in the future.

We are all agreed about the need for an integrated approach and for a smooth patient pathway. Clearly, primary care potentially has a very important role to play. However, it needs to step up to the plate. If acute hospitals are to reduce the scale of their

operations, more will be expected of primary care. Yet acute hospitals are open every hour of the day: primary care is not. Indeed, there are often very big issues about how primary care can be accessed out of working hours. The out of hours services are not always as effective as they might be, and there are some practices where patients know that it is very difficult to get attention unless they turn up at the convenience of the doctor, and so they then end up at the accident and emergency department. As I read where the NHS is going, this is no longer going to be acceptable. If money is being taken away from acute care and more money is being spent on primary care, which must be the logical outcome of clinical commissioning groups, unless those clinical commissioning groups can ensure that GPs do what is necessary to ensure that primary care takes up the responsibility, we are going to end in great difficulty, where acute care services will continue to be demanded by patients and money is being spent on primary care but it is not doing the necessary job. Therefore issues around the monitoring and performance management of primary care become very important indeed.

The Government have decided not to place the contracts of GPs within clinical commissioning groups. I understand that because clearly there is another potential conflict of interest. They are to be held at the local offices of the national Commissioning Board. However, there are real questions to be asked about how bureaucrats, as the Government seek to call them-I like to think of them as managers-are going to handle those contracts. What will happen within a particular clinical commissioning group if there is a group of GPs who simply will not do what is required of them to make a contract work with a local hospital? For instance, there may be a risk-share arrangement with a local hospital, where essentially agreement is made on the contract price, but part of it is very much about demand management, where there is a risk share between the clinical commissioning group and the acute trust. That will depend on all the GPs within a clinical commissioning group doing what is necessary, playing their part and contributing to demand management measures. Frankly, there are a lot of GPs who will not have anything to do with that. We know that at the moment. It is happening everywhere, up and down the country, with GPs who do not give a damn about anything to do with demand management. What will happen? Who will be able to intervene in those circumstances? Clinical commissioning groups do not have many levers when it comes to poor performance among general practitioners. I suspect that the national Commissioning Board will not have the expertise either. That is why this group of amendments is so important. We all know that primary care can make a huge contribution to a good NHS in the future, but we have to admit that, of all parts of the NHS, we can probably also find the poorest quality of service as well. That is why we are looking for reassurance from the noble Earl that this new system will be able to deal with those poor performers.

Earl Howe: My Lords, I am grateful to the noble Lords, Lord Kakkar and Lord Patel, for their contributions to this debate and, indeed, to other noble Lords who have spoken. We have heard some very powerful and persuasive arguments. I have listened very carefully to them.

Amendments 43A and 43B highlight the concerns that I expect all of us in this Chamber share in relation to the need to ensure high-quality primary care for all patients. The noble Lord, Lord Hunt, made some very telling points in that regard. Of course, there can be no doubt that good primary care contributes to good healthcare outcomes overall. I fully agree that the NHS Commissioning Board should be held to account properly for its performance in commissioning primary care. I do not think, however, that the right way to achieve that is to prescribe that this must be part of the mandate. Our aim is that the mandate should have at its heart the NHS outcomes framework, which covers the range of care that the NHS provides. I make the simple point that good primary care will be essential to improvement against the NHS outcomes framework.

More widely, the department will be keeping under review the performance of the board and the way that it carries out its functions, including its direct commissioning. What matters here are the accountability mechanisms and how those in the system are monitored and held to account. Just as the board will have a commissioning outcomes framework to hold CCGs to account for the quality of their commissioning, it will be important to have robust and transparent information to assess the quality of what the board commissions itself.

We come back to what the Bill already says: it places duties of quality on the Secretary of State, on the board and on CCGs, requiring each of them to exercise functions with a view to securing continuous improvement in the quality of services provided to patients. The Bill also sets out robust arrangements for holding those bodies to account for delivering quality improvement. As noble Lords will be aware, the Bill already requires the board to submit a business plan setting out how it proposes to exercise its functions, and a report setting how it has exercised its functions, to the Secretary of State on an annual basis. In turn, CCGs must also submit their commissioning plans and annual reports to the board. Both the board, in reporting to the Secretary of State, and CCGs, in reporting to the board, will be expected to demonstrate how they have fulfilled their quality improvement duty, including in relation to primary care. Consequently we expect, for example, that both the board and CCGs will wish to monitor the standard of care and services provided by all primary medical services providers in fulfilling their duties.

It is possible that we will need a dedicated objective relating to primary care in the mandate-I am not ruling that out. It would be better, though, not to prescribe that in primary legislation. What matters is that there are clear and effective accountability arrangements, and the Bill as it stands provides flexibility to ensure just that.

The noble Lords, Lord Kakkar and Lord Rea, asked about the QOF. I agree with the noble Baroness, Lady Finlay, that the QOF is a separate issue, but I can say that the whole of the QOF is kept under review in consultation with the profession to ensure that it reflects the best available evidence and supports continuous improvement in the quality of care for patients. Over the coming months we will continue to discuss with the profession and its representatives how to focus the QOF on securing better healthcare outcomes and what that means for existing GP contractual arrangements.

I turn to the final amendment in this group, Amendment 95A. The Bill already ensures that the board has the information that it needs to demonstrate how it has fulfilled its duties. CCGs are required to provide information to the board in the form of the annual commissioning plan and annual report. In addition, the board and CCGs are under a duty to co-operate. In the normal course of business we expect this to involve the sharing of information as necessary but, in the event that a CCG might have failed, be failing or fail to discharge any of its functions, the board's powers enable it to require any information or documents that it considers necessary from CCGs.

The noble Lord, Lord Hunt, posited the situation that there might be reluctant GPs who did not fulfil their part of the bargain, whatever that was, with the acute sector. There needs to be a way of investigating allegations that actions by GPs in their practices are adversely affecting a clinical commissioning group. Where a general practice is operating in such a way that it is a barrier to a clinical commissioning group meeting its functions, it will be for the commissioning group to work with the members of that general practice to support it to improve and contribute to the work of the commissioning group as a whole. Ultimately, if it is unable to do so, a clinical commissioning group may need to refer such cases to the NHS Commissioning Board, along with the evidence of the failure of the practice and details of any support that the commissioning group has provided to the practice to help it overcome any perceived difficulties.

Among other matters, the board may wish to consider if the practice's actions are in breach of the practice's primary medical services contract. Separately, the NHS Commissioning Board will have the power to investigate the suitability of individual GPs under the medical performers list provisions. As the noble Lord will know, this power is currently with primary care trusts.

In a nutshell, therefore, the Bill already imposes a duty on CCGs in respect of the mandate and allows the board to ensure that CCGs fulfil it. Further specific requirements in relation to providing information to the board are therefore unnecessary, so I hope that what I have said reassures the noble Lords, Lord Kakkar and Lord Patel, sufficiently to enable them to withdraw their amendment.

Lord Kakkar: My Lords, I thank the Minister for, as always, his thoughtful response and consideration of the amendments. I remain somewhat anxious about whether there is going to be sufficient attention and opportunity to deal with the question of performance in primary care and the management of that performance to ensure that the very best clinical outcomes are achievable for all patients across the country.

I welcome much of what the Minister has said with regard to potential further consideration of how mechanisms other than a specification in the mandate on the question of primary care performance might work. I wonder whether it might be possible for him to enter into further dialogue on this matter so that there can be clarity. It would be unhelpful for the future if a great emphasis were placed-in fact, if there were a momentum-on moving practice from the secondary care environment, where there is a relentless evaluation of clinical outcomes and which has done so much to improve clinical outcomes for our patients because of the attention paid to those matters, into a primary care environment where an objective assessment of outcomes was not always possible and where, as a result, what we all hope will be achieved through the Bill-a health gain for patients and population-might therefore inadvertently be lost. With the opportunity to have a further conversation with the Minister prior to Third Reading, I beg leave to withdraw the amendment.

Amendment 43A withdrawn.

Amendments 43B and 44 not moved.

Amendment 45

Moved by ***Earl Howe***

45: Clause 22, page 17, line 9, at end insert-

"( ) Requirements included in the mandate have effect only if regulations so provide."

Amendment 45 agreed.

Amendment 46 not moved.

Amendment 47

Moved by ***Earl Howe***

47: Clause 22, page 17, line 21, at end insert-

"( ) Revisions to the mandate which consist of adding, omitting or modifying requirements have effect only if regulations so provide."

Amendment 47 agreed.

Amendments 48 and 49 not moved.

Consideration on Report adjourned until not before 8.29 pm.

Amendment 49A

Moved by ***Baroness Williams of Crosby***

49A: Clause 22, page 17, line 38, at end insert-

"Patients' interests to be treated as paramount

The Board must, so far as resources allow, exercise its functions on the basis that the interests of patients are paramount."

Baroness Williams of Crosby: My Lords, owing to the need to make progress I shall speak briefly, but my noble friend Lord Marks of Henley-on-Thames will be speaking in greater detail about the amendment.

It is short, perhaps deceptively short, but it has real significance and is related in this group specifically to Amendment 94A. The government amendments respond to aspects of these amendments, too. Amendments 49A and 94A set at the very centre of the Bill, which has the full support of all of us who want to see the NHS thrive, that the interests of patients should be paramount. The importance of that phrase is that in every single aspect of what we try to do, it shall always be the case that this is the way in which we think-whether it is how CCGs operate or how foundation trust hospitals operate. This has emerged in our debates increasingly as the central concept-the one to which we should always refer back. That will give us the guiding light that we need for the Bill.

It is significant because, in many cases, patients can be very vulnerable. They can be vulnerable through lack of information and in some cases by not being consulted. They can be vulnerable, as the noble Baroness, Lady Hollins, has mentioned, through the lack of advocacy by people who understand the basis of the choices they have to make. This phrase about the significance and the importance of patients' interests being paramount therefore also affects a recognition that where patients are vulnerable they need the help of counsellors, advisers and in some cases advocates, so the concept behind this covers those areas as well.

I want also to point out briefly that government Amendment 56 is helpful in spelling out the matters on which patients should be particularly consulted. I will not repeat them but the amendment is helpful in setting out very clearly issues of treatment and the way in which patients should be offered different forms of treatment and then to make choices among them.

I do not intend to keep the House. I shall conclude my remarks. Whatever side of the House we may be on, I hope very much that the concept of the paramountcy of patient interest will be something that all of us can support, understand and advocate with respect to the future of health services. I beg to move.

Lord Marks of Henley-on-Thames: My Lords, the reasons for Amendments 49A and 94A have been briefly-as she explained-and eloquently expressed by my noble friend Lady Williams of Crosby. One of the fundamental principles which the Government have assured us runs right through this Bill is that the NHS, as reformed by this legislation, will be committed to putting patients first. That is a critical matter for most of us in this House and the public at large. Why do I believe that this principle needs stating in the Bill? It is because the Bill introduces an entirely new structure for commissioning services, with commissioning by clinical commissioning groups within a framework established by the board to requirements and objectives set by the Secretary of State. However well understood here, this proposed structure is widely mistrusted outside this place.

I believe that a legislative statement that the commissioning process will put patients first is very important, both because it will enshrine in law this fundamental principle and because it will give the public an assurance that this is indeed the aim and purpose of the new commissioning process. My noble friend the Minister was kind enough to write to me in relation to this amendment to say that while he completely agrees that we must always put patients first, the Bill already provides for that and that there are "technical reasons" why our amendments should not be accepted.

The Minister is entirely right to point to the commitment to the comprehensive health service in the Bill and to the duties of the board and the clinical commissioning groups, now enshrined in the Bill, to promote the NHS constitution. I agree that those are powerful provisions. The NHS constitution is an important and extremely valuable document. It does indeed contain a commitment to putting patients first. At the back of the document in the expression of NHS values it says:

"Working together for patients. We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries".

No one could fail to regard that expression of values as admirable, but it covers the whole sweep of NHS functions and is very general. The provisions that we seek by way of these two amendments are specific to the commissioning process. They will impose a binding obligation on the board and the CCGs of which they will at all times be aware. Moreover, our amendments are directed particularly at responding to what is probably the principal concern that members of the public have about these reforms: that the new commissioning process may lead to the marketisation of the NHS and that patients' interests may be lost in that process. I do not believe that, but I do believe that these amendments would help make it crystal clear that this concern is unfounded.

The other problem we face is this: all the evidence, even that emanating from within the NHS, suggests that there is widespread unawareness of the very existence of the NHS constitution, let alone of the detail of its provisions. At the very least, therefore, given the emphasis that we are putting on the NHS constitution, it is crucial for the Government to make it quite clear that a great deal is expected of the board and of CCGs in the exercise of their respective duties under the Bill to promote awareness of the NHS constitution. In addition, the department should commit itself to an even wider, more effective campaign to publicise both the existence and the content of that constitution.

As to my noble friend's second point, I regret that I do not understand the technical reasons which are said to require the rejection of these amendments. It is perfectly true that the NHS will always have to face resource constraints which may necessarily determine many, even most, commissioning decisions, but our amendments accept entirely that the paramountcy of patients is always subject to resource constraints. The board or a CCG must, so far as resources allow, exercise its functions on the basis that the interests of patients are paramount. Nor do our amendments, either expressly or impliedly, reduce the ability of commissioning groups or the board to prioritise the treatment of particular groups of patients where they think appropriate. They simply

make the interests of patients in general paramount or, to use my noble friend the Minister's phrase, make sure that commissioners put patients first.

The use of that word "paramount" in these amendments was modelled on the Children Act 1989 and the principle which runs like a golden thread through that legislation that the interests of children are paramount. That legislation has been widely applauded for embodying that principle, which firmly governs its interpretation and its implementation. It is precisely because it is embodied in the legislation itself that that Act is so well respected.

I still hope that my noble friend the Minister might reconsider whether he is not prepared to accept in this Bill the expression of the principle which he has so often expressed: that, throughout the commissioning process, the interests of patients must be paramount.

Baroness Cumberlege: My Lords, my Amendment 142 has been grouped with this amendment. I have brought it forward because I am anxious that when we talk about "patient and public involvement" we should be clear as to exactly what we mean by it. I am grateful to my noble friend Lady Jolly, who has also put her name to the amendment.

I am also anxious that we embed what I will call PPI for shortness-patient and public involvement throughout healthcare in all its forms. I say so in the knowledge that few people understand what this means. However, no one understands it better than my noble friend Lord Howe. He was a doughty fighter for community health councils, those much beloved organisations that knew how to campaign and influence the delivery of services. The culprit sits before me on the opposition Benches.

When I was chair of the Brighton Health Authority I had a huge respect for my CHC. Indeed, we even commissioned it to carry out surveys within the NHS. The effect was electric: no punches were pulled and the pressure on us was irresistible. It really knew what was being delivered, where the glitches were and where services were inadequate and needed improving, and it was not shy in making our shortcomings very public indeed. The CHCs had power and could refer proposed changes in services directly to the Secretary of State. The subsequent inheritors of their responsibilities-patients' forums and LINks-have been systematically neutralised to ensure that they do not have the power to be really effective; that they are not inconvenient bedfellows; and that, despite the undoubted commitment of individuals, they can be largely ignored.

At last we have an opportunity to put matters right and to show that we have genuine credentials in making patient and public involvement a force for good, ensuring that

patients and the public are the heart of their NHS. I was encouraged when in one of our earlier debates my noble friend, in answering an amendment, mentioned that the Secretary of State required four tests for the reconfiguration of services, one of which was robust PPI.

I had an interesting letter from my noble friend dated 2 February which again showed his clear commitment to effective PPI. However, the Bill does not seem to match up to that commitment. Different wording is used for PPI in different parts of the Bill-a court of law would surely assume different intentions-and the wording is weak in places. There are three types of involvement. The first is shared decision-making with individual patients on their care, to which the remainder of these amendments relate. The second is the HealthWatch England and local healthwatch structures through which patients and the public feed in their views-the way in which people start a conversation with the NHS. The third is PPI by the service in its decision-making-the way in which the service starts a conversation with local people and the subject of this amendment.

No business would attempt to plan its products or its services without doing market research. If it did, it would fail. We expect the same for the NHS. However, PPI is more important than just market research: it imports the values that we as a society expect from the NHS, making sure that it thinks as we think. PPI must be in the DNA of the service so that those who plan and run it feel as if they are planning and running it for their own families and looking after their own mothers in that hospital bed.

The PPI requirement was introduced in the Health and Social Care Act 2001 in response to the Bristol Royal Infirmary public inquiry. At Bristol, between 1991 and 1995,

> "one-third of all the children who underwent open-heart surgery received less than adequate care",

and up to 35 children under one died as a result. As Bristol concluded,

> "vulnerable children were not a priority, either in Bristol or throughout the NHS".

What an indictment. These are catastrophic failures and we must not forget them. Sadly, evidence shows that we have not yet succeeded in making the NHS as a whole think as we think. We need look no further than Mid Staffordshire.

Bristol recommended that:

"The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of healthcare are made".

The report goes on to say:

"The public's involvement in the NHS should particularly be focused on the development and planning of healthcare services and on the operation and delivery of healthcare services, including the regulation of safety and quality, the competence of healthcare professionals, and the protection of vulnerable groups".

My amendment defines what makes effective PPI across the commissioner, provider and regulatory system, as Bristol recommended. Triggers for the duty will vary depending on the body, and it must always be proportionate. Monitor is covered in my Amendment 166, which we will be debating later.

My noble friend explained to me in his letter that statutory guidance would cover these matters, as it does now. Mid Staffordshire has demonstrated that this approach simply does not work. Furthermore, the duty of autonomy in Clause 4, even as amended, gives all bodies in the Bill discretion to challenge anything-such as statutory guidance-as being unduly burdensome. We must therefore have crystal-clear, comprehensive requirements for effective PPI as explicitly defined on the face of this Bill.

There are three ways in which the clauses in the Bill fall short of this. The first is: telling, not asking. The duty can be met merely by providing information without getting any response or taking any notice of it. Involvement means not assuming that you know whether an issue is something patients only need to be told about, but asking them. The second is: theory, not reality. Patients are not required to be involved in finding out whether plans, proposals or decisions actually advantage or disadvantage patients in practice. The third is: nothing about us without us. Patients must be involved in all functions affecting patients, such as quality improvement or health inequalities, not just in commissioning.

However, the problems are greater than these. My noble friend's letter to me seems to suggest that, as commissioning and providing have been split in the Bill, PPI is to be similarly split. This would enable the PPI buck to be passed between commissioner and provider and leave no one responsible for guaranteeing that effective PPI happened if providers-private or NHS-failed to do it. Commissioners are likely to use the Department of Health model contracts that do require providers to involve patients; and NHS

providers have their own statutory duty. So far, so good. However, once commissioners have granted such contracts, they can wash their hands of involvement by the private or NHS foundation trust provider because they no longer have ongoing responsibility.

Subsection (1) of my amendment defines the three involvement elements: giving information, seeking comment on it, and inviting participation in monitoring whether patient benefit emerges at the end of it all. For example, the duty now relates only to designing a commissioning specification for accident and emergency, not monitoring whether it actually works in practice. Subsection (2) involves patient representatives and carers as well as patients. Patients on mental health section may not be able to get involved in commissioning, but those who can represent their interests, as they have previously been on sections themselves, should be able to do so. The NHS outcomes framework, against which we expect commissioners to perform, includes:

"Enhancing quality of life for carers",

so we must make sure that they are involved. Subsection (3) gives the commissioners a lead responsibility for PPI across the local health economy to avoid buck-passing between organisations. Subsection (4) applies involvement to all the relevant functions of the NHS Commissioning Board and CCGs, subject to the existing proportionality limitation. The CCG should, for example, not attempt to address health inequalities without involving those who suffer them.

I have thought a great deal about this issue over many years, as has my noble friend the Minister, and over the past weeks he has been hugely generous with his time in talking to us about it.

Your Lordships have spoken often of the strengths of the NHS and the warm place that it has in the hearts of the people. I strongly support its remarkable ethic that whether you are young or old, black or white, rich or poor, you can get treatment, largely free at the point of use. But none of us can deny that its underlying problem is how little influence we, users and taxpayers, have in a near-monopoly service that is organised and run by those who work in it. We need to reorder the balance, and my amendment seeks to do just that.

Lord Harris of Haringey: My Lords, I have lost track, since I first became a community health council member in 1977, of how many reorganisations there have been of the National Health Service and how many have all said somewhere in the White Paper or in the preamble or in whatever else it might have been that the Government of the day were committed to putting patients first, or at the centre of the NHS. I recall White Papers with titles such as *Putting Patients First*, which were all about reorganisation of

the health service and the administration. I recall successive Secretaries of State-many of whom are not in their place tonight, although they could be as Members of your Lordships' House-telling us proudly that their particular reorganisation was somehow going to ensure that patients would, for the first time ever, be at the centre of the NHS. So I can understand why the noble Lord, Lord Marks, and the noble Baroness, Lady Williams, thought that it might help to try to write that into the Bill. I can understand, too, how the Minister felt that it could be resisted-as, presumably, every previous ministerial occupant of the role that he currently fulfils has resisted writing it into the Bill in the past. But I suspect that simply having statements that say that the basis is that the interests of patients are paramount is not going to be sufficient. Indeed, I suspect that with some of the arrangements envisaged in the Bill, that may produce some genuine difficulties. If, for example, you are a private sector company providing services to the NHS your duty as directors is to the shareholders of that company. So I can see why it will produce a tension-and, no doubt, why the Government will resist the earnest endeavour of the noble Baroness and the noble Lord to get this into the Bill.

The amendments in the group in the Minister's name are rather helpful, however, because they are specific. They talk about the duty to promote the involvement in various stages of the process. They place a duty on the board and on CCGs to involve patients in the prevention and diagnosis of their illness and their care and treatment. The experience is that where there is that duality, when patients are involved in the assessment of the treatment and the sort of treatment that is to be followed for their illness, the way in which that treatment is then followed by the patient is far greater as a result of that involvement. What is more, patients are usually expert in their own conditions, particularly if they are long-term or chronic conditions. They will often know as much about it as their general practitioner or, indeed, many other people who are engaged in their care. So that principle of involvement is absolutely right. I rather suspect that the Minister's amendments will do far more by making it clear what the expectation is than rather grand statements about the interests of patients being paramount, as we have seen so many times in the past.

In her very full introduction to Amendment 142, the noble Baroness, Lady Cumberlege, has given a very clear and important explanation of why patient involvement is so important, and has drawn a careful distinction between the different types of involvement that need to be addressed. I hope that in responding to the noble Baroness's amendment the Minister will clarify-before we get on to the important amendments about healthwatch which we will come to in due course-exactly how the various separate functions and requirements that the noble Baroness identified will be met by the structures proposed in the Bill, and in particular how they will be met in terms of the resources available and the resources guaranteed. That will be the test of

whether these changes matter. The noble Baroness indicated the different sorts of patient involvement that are necessary. It is now down to the Minister to tell us how he will deliver in practice, rather than in fine words, the changes that he is proposing.

Baroness Wheeler: I am pleased to speak in support of the Government's Amendments 56, 97 and 98, which take an important step along the route of making the Bill more explicit on the duties of the NHS Commissioning Board and clinical commissioning groups to promote patient involvement in decisions about an individual's care and treatment. We particularly welcome the requirement for the board to publish guidance for CCGs on the patient involvement duty. We argued strongly for this in Committee. It will go some way to ensuring that CCGs are clear about what is required of them to meet the duty of involvement of each patient. We know that the evidence shows that many commissioners are currently unaware of the increasing evidence that involving individual patients in their care and treatment is proven to be more clinically effective, provides better patient experience and makes better use of healthcare resources. The guidance will enable strong signals to draw commissioners' attention to the proven interventions that they require from their providers.

CCGs will need considerable help and support to bring about the changes we need, so clear and explicit guidance to them will be crucial. For individuals, participation must mean involvement in care planning and support for patients who manage their conditions. Sharing in the choice of treatment involves major cultural changes in the behaviour, approaches and attitudes of key professionals from across the specialisms. As we have stressed before, this means changing the way that patients and clinicians, in particular, relate to each other, and changing the way that the NHS relates to patients in terms of, for example, information provision, the organisation of clinics and the style of consultation that professionals have with patients.

Amendment 142 underlines the importance of the provision of information to patients and is supported by us. It includes the participation of the patient in monitoring systems that measure the impact of service delivery or the range of services available, and this is welcome. My noble friend Lord Harris has commented on Amendments 49A and 94A, and I endorse those comments.

In Committee, noble Lords strongly supported the call from patient organisations and other key stakeholders for a definition of patient and public involvement to be included in the Bill. The guidance to CCGs will need to address this issue. I hope that the Minister will also ensure that it focuses on ways in which patients will be genuinely engaged during the development of the commissioning plans rather than just consulted on plans after they have been drawn up. Guidance will help patients, carers and their representatives make informed decisions. This group of amendments form the basis for

moving forward. We look forward to the Government also looking favourably on the subsequent amendments, which would also provide real impetus to the patient involvement agenda that we need.

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, we have spent a good deal of time in debate on this Bill discussing the issue of patient involvement, and for good reason. Patients rightly expect to experience responsive health services where they are treated as individuals. It is central to the Government's vision for the NHS for patients to become genuine partners in decisions about their health and treatment, with services designed around their needs. The Bill will lay the foundations to achieve that. So I understand completely the motivation behind my noble friend Lady Williams's suggestions in Amendment 49A and 94A to place an additional duty on commissioning bodies when taking decisions to put the interests of patients above all other considerations, as far as resources allow. On the face of it, this sounds obvious, and I am deeply sympathetic to the principle. However, I think that I am going to have to seek to persuade my noble friend that it would be extremely hard to get this right.

In the first place, I think we would all agree that the primary duty in the Bill is the duty to promote a comprehensive health service, free to all at the point of use, as set out in Clause 1 and as agreed and debated at length by your Lordships' House. We should certainly not, I suggest, wish to detract from or conflict with that. The second reason why I suggest that the amendment is not right is that the NHS has to plan and cater for the health needs of the population as a whole, not just those who are currently patients. That is why the duty on CCGs is to commission services to meet the reasonable requirements of all those for whom they are responsible. In addition, the board and CCGs will be under further duties in relation to improvements in quality, promotion of integration, the involvement of patients in decisions and as regards public involvement, duties which all serve in different ways the interests of patients.

Above all, in addition to the duty to have regard to the NHS constitution, they will be under new duties, as my noble friend Lord Marks rightly pointed out, in relation to promoting the NHS constitution. Surely that should be the place for drawing together the fundamental rights and principles that patients should expect from the NHS. As my noble friend knows, the Bill embeds the NHS constitution firmly in the NHS of the future and will ensure that all NHS bodies comply with and uphold it. I say to my noble friend Lord Marks that the new duty means that when exercising their functions, the board and the CCGs must act with a view to securing that services are provided consistently with the NHS constitution and to promoting awareness of the constitution among patients, staff and the wider public. In the past, a number of noble Lords have spoken about

wanting to have some kind of touchstone in this area of the Bill. I think that the NHS constitution fulfils that precise role.

In Amendment 142, my noble friend seeks to establish additional requirements that would apply to the exercise of the duties to the public. Although I also agree with the sentiment behind those proposals, I hope to convince my noble friend that they are already appropriately covered by the duties as they stand. The duties as currently drafted allow scope to determine the best method of involvement in each instance. The board, or a CCG, would need to be able to demonstrate that it had acted reasonably when exercising this duty. They are not restricted to the involvement of individuals only by way of consultation or by the provision of information, as my noble friend seemed to imply. They would apply throughout the planning stage and the development and consideration of proposals. They would also apply to anyone,

> "to whom ... services are being or may be provided",

and would therefore encompass carers or other representatives.

To provide further reassurance on these points, we have already amended the Bill to require CCGs to set out in their constitutions what arrangements they will make for exercising this duty and the principles that will underpin their approach. This will therefore be assessed as part of the establishment process. The board will also have powers to produce guidance for CCGs on the exercise of the duty, which CCGs would have to have regard to and which could set out what might be reasonable in different situations. Of course, the views of patients should also be integral to the evaluation of the performance of health services. The duty on the board and CCGs as to improvement in the quality of services already requires that specific consideration must be given to the experience of patients. The views of patients and the public on the effectiveness of any change in services would therefore be captured in the normal way as part of this ongoing assessment.

One area where there is a deliberate difference is that the wording of the duty on the board and CCGs is intended to reflect the distinction in the Bill between bodies that commission services and those that provide them. Both the wording of the new duty and the current provision in Section 242 of the 2006 Act apply to arrangements to commission health services which are to be provided by others. This would therefore capture any changes that are a result of the commissioning decision.

At present, however, PCTs also provide some services directly, whereas the board and CCGs will not. Neither will they have managerial oversight of NHS providers in the way that PCTs and SHAs do now. The difference in wording is therefore intended to reflect

this. NHS trusts and foundation trusts will be directly accountable for ensuring that they involve and consult the public under Section 242. In relation to foundation trusts in particular, there will be a stronger role for governors and members in holding them to account.

I am also unable to agree that it would be appropriate to extend the application of this duty to the exercise of all the functions of the board or a CCG that might relate to the provision of services. The matters to which the duty applies are the same as those in Section 242 of the 2006 Act. Certainly the board and CCGs could choose to involve people in other aspects of their work, and no doubt they will do so where this would add value, but creating a duty to involve people in every detail of the board's work would not be practical.

I hope that I have been able to offer sufficient reassurance to my noble friends for them not to press their amendments.

Finally, I should like briefly to explain Amendments 56, 97 and 98 in my name on the Marshalled List. I was struck by a point that the noble Baroness, Lady Finlay, made in Committee about the importance of differentiating between public engagement and the involvement of each individual patient in the management of their care and treatment-and that is surely right. It is for precisely this reason that we have included in the Bill new duties for the NHS Commissioning Board and CCGs in relation to promoting opportunities for patients to be fully involved in decisions about the services they receive as individuals.

Nevertheless, it was apparent to me from our debates that the purpose of these new duties was not quite clear enough. This point was raised in the meetings that I have held with many noble Lords in recent weeks, in particular the noble Lord, Lord Warner. I am therefore proposing these amendments to new Section 13H, inserted into the 2006 Act by Clause 22, and new Section 14T, inserted by Clause 25. They put it beyond doubt that the duties on the board and CCGs in relation to promoting the involvement of each patient apply to decisions related to the prevention and diagnosis of illness in the patient and any care or treatment that they receive. This drafting follows the language that is used in defining the health service so as to encompass the full range of activity that could be provided as part of the health service. I was grateful for the supportive remarks of the noble Lord, Lord Harris of Haringey, on these amendments.

The amendments also impose an obligation on the NHS Commissioning Board to issue guidance to CCGs on the discharge of their duty under new Section 14T, to which CCGs must have regard. This will ensure that support will be made available to CCGs on best

practice in securing effective patient involvement. I hope that it indicates the Government's clear commitment to this objective.

I am pleased that the Health Foundation and National Voices have strongly welcomed these changes as representing,

> "a clear signal that commissioners should be making sure patients are more engaged in their own care and treatment".

I am extremely grateful to them for their support in ensuring that the Bill is as strong as possible on this point.

Baroness Williams of Crosby: My Lords, I thank the noble Earl very much for the amendment, and I am grateful to him for what he had to say. I beg leave to withdraw the amendment at this point but hope very much that he will come back to it at Third Reading.

Amendment 49A withdrawn.

Amendment 50 not moved.

Amendment 50A

Moved by ***Baroness Finlay of Llandaff***

50A: Clause 22, page 18, line 15, at end insert-

"( ) In discharging its duty under subsection (1), in relation to specialised services, the Board must exercise its functions in accordance with current NICE guidance."

Baroness Finlay of Llandaff: My Lords, we come to another group of amendments that relate to the Commissioning Board. These are three separate amendments but they are grouped together because they all relate to the functioning of the board.

The first, Amendment 50A, aims to embed quality and good practice in services while eliminating unacceptable variations in standards of specialist services by ensuring that the NHS Commissioning Board conducts its functions in accordance with NICE guidance. Unfortunately, we know that NICE guidance is not being observed as widely as one would hope. The amendment has been particularly strongly supported by the Neurological Alliance and a lot of other groups representing patients with less common conditions, which feel that their services are not necessarily as good as they should be.

I shall give some examples from neurology. If epilepsy is suspected, the NICE guidance currently says that these patients should be assessed by a specialist, but 49 per cent of acute trusts have none. The guidance says that they should be seen urgently within two weeks but 90 per cent of patients are not seen within that timeframe. It says that they should have access to an epilepsy nurse but 60 per cent of acute trusts do not have one. With regard to multiple sclerosis, a relatively common condition across the country, 56 per cent of the 89 MS centres are multidisciplinary; the remainder are not. One-third of Parkinson's patients are waiting longer for diagnosis than the NICE guidance suggests that they should.

Unfortunately, some pathfinder commissioning groups have vocalised that they do not see a need for specialist services and indeed that they are not following NICE guidance. That is why the amendment is worded as it is, with the phrase,

"in relation to specialised services".

It may seem as if that is superfluous to the wording already in the Bill, but I have worded it in that way to bring a focus on to specialised services.

NICE is an independent way of establishing the evidence for best practice, and its appraisals are widely recognised around the world as being of a high standard and setting high standards. It also provides a basis on which services can be accredited. There are clinical guidelines and services can be audited so that they can be assessed on the standard that they are providing. That allows quality outcomes and patient outcomes to be measured.

Amendment 63A relates to commissioning for conditions that are less common. This amendment in particular has very wide support. Quite apart from neurological disease, there are patients with haematological diseases such as sickle cell or haemophilia, conditions that are affecting children and young people into early adulthood. These patients need to be able to access services rapidly, wherever they are living. These services become part of the general haematological services available where they are, but they have to be provided to a high standard. In the past we had a tragedy with patients with haemophilia, and we see the problem of patients with sickle cell who are not appropriately treated and as a result have much more damage than they might otherwise have. There is also a risk of the inappropriate prescription of analgesics at the wrong time and at the wrong dose, which can result in long-term dependency without establishing good pain control, whereas during the acute crisis patients have terrible pain and need adequate treatment. Sadly, some of these young people have been labelled as being addicted because the severity of their pain has not been recognised.

Other areas that such commissioning needs to focus on include trauma centres and severe burn units and conditions such as immunodeficiency, where again there is a critical mass for the service to be provided. Some services have improved enormously, as has happened particularly in London, but the NHS Atlas of Variation shows a 25-fold variation in anti-dementia drug prescribing across England. I give that as an example of the wide variation in care provided. Many years ago my tutor and mentor Julian Tudor Hart described in a paper for the *Lancet* the perverse relationship between the need for healthcare and its actual utilisation. The principle behind Amendment 63A is to try to make sure that we do not inadvertently leave the inverse care law being perpetuated once this Bill is enacted.

Amendment 64ZA is the last amendment in this group. This relates specifically to emergency services and unscheduled care. This amendment has three parts which I would like to explain briefly. First, the amendment seeks to ensure that emergency health services are adequate for the population served. Until recently, emergency departments have tended to be placed in a rather ad hoc way, but work done in London, which has designated emergency services and major trauma centres, has been shown to improve clinical outcomes for patients. These have been calculated on a population needs basis.

The second part of the amendment recognises the importance of integration between emergency care and specialised networks and associated specialties. This is particularly important because the emergency department sits on a spectrum of provision. Patients may be seen in primary care and may be sent in to the emergency department either in or out of hours, but there is good work to show that it is only 10 to 30 per cent of cases that could be classified as ones that could have been dealt with in primary care. However, primary care is increasingly taking a gatekeeper role. With a shortage of beds and a decrease in resources, there is also a rationing role in the other parts of secondary care.

The third part of the amendment relates to emergency departments. The one place that remains with its doors constantly open with no gatekeeper role and with open access is the emergency department. Patients increasingly turn up in the emergency department with acute conditions that need management and treating. These conditions are completely undifferentiated, unscheduled and range from the most severely life-threatening to others which certainly need to be treated fast. These can be less immediately serious, although if they are left inadequately treated they can become life-threatening in a remarkably short time. The nature of unscheduled care means that these patients have to be planned for in consideration for the way that primary care is working, in and out of hours. Where out of hours is inadequate more and more people

will go to the emergency department or may indeed be advised to by telephone triage services, but they may be inappropriately advised. This accounts for the range of 10 to 30 per cent of those who could have been treated in primary care.

I understand that the Commissioning Board is developing a clinical outcomes framework. That should make a link between the national framework for the Commissioning Board and the clinical commissioning groups, with consultation on NICE indicators, some of which have already been developed for primary care. This clinical outcomes framework should also provide guidance for clinical commissioning groups on how to commission emergency care locally. I hope that the Minister will be able to assure me that this guidance will continue so that work with the colleges, particularly the College of Emergency Medicine, will contribute to the whole commissioning framework.

Emergency medicine is different from other parts of the service because competition is not appropriate and choice, as we talk about it in other parts of the Bill, does not apply. People who need emergency treatment need to be taken to an emergency department that can deliver a service to meet their clinical needs. These patients may be unconscious; they certainly cannot choose where they will go. They also need to be assured that every emergency department to which they are taken will meet a standard that will provide them with the care that they need. Competition has also been shown to be inappropriate. *Breaking the Mould without Breaking the System*, a document that was published last year by the Primary Care Foundation and the NHS Alliance, pointed out that tendering in emergency medicine results in a decrease in the quality of services because it is expensive, costing around £100,000 for the commissioner and each provider involved. The document also pointed out that the quality of care is driven up by working with providers to look for incremental improvements, rather than by going out for a competitive tendering process. This document is very helpful to commissioners because it also points out how triage is less safe than rapid see-and-treat processes and is used to compensate for delays caused by poor capacity planning.

When accident and emergency departments are overwhelmed the admission rate goes up, but a well functioning department will be able to decrease the number of admissions. The number of patients retained overnight needs to be looked at in relation to the severity of their conditions and not as an absolute number. Without good services for the frail elderly and without somewhere else for patients to go to be observed, they need to be admitted into observation wards overnight because they often deteriorate rapidly, particularly those whose symptoms and history suggest that they are on the cusp between potentially improving and potentially deteriorating. If they are sent home, they may be at great risk.

There is a need for collaboration from primary care right through to secondary care. The problem is that without incentives for primary care to improve home-care services for the frail elderly and out-of-hours services, an increasing number of these patients will end up at the doors of the emergency departments, as happens at the moment. With the decrease in the number of beds, it becomes increasingly difficult for them to be placed anywhere, yet they are often too frail to be sent home at midnight or in the early hours of the morning and need to be kept in overnight.

Emergency medicine acts as a portal. The vulnerable come in with their life stories. There is no pressure group to argue for patients who access emergency medicine because they are a completely heterogeneous group. Disease groups, such as those for neurological diseases, cancer, diabetes and so on, can argue for their patients but emergency medicine covers just about everybody. It has been estimated that, on average, a member of the population accesses an emergency department once every three years, compared to once every six years for out-of-hours primary care services. Therefore, I hope that the Minister will be able to reassure me that emergency medicine will be looked at in its totality and across the spectrum from primary to secondary care; and that commissioning will take into account that it is in a different position, with its constantly open access portal, from the other services in the NHS. I beg to move.

Baroness Williams of Crosby: My Lords, perhaps I may briefly intervene in the debate on this extremely important amendment. In countries like the United States, where there is no effective health system for those who cannot afford very substantial sums of money, emergency admission has become the last resort for such people. The noble Baroness, Lady Finlay, is right but we should take it one stage further. We know, from very recent reports on the difference between the likelihood of survival in an emergency situation between weekdays and the weekend, that out-of-hours provision is of substantially lower quality than that provided by regular doctors in a good hospital. This is very serious. One of the great mistakes made in the last contract for general practitioners was the almost complete transfer of out-of-hours work to private agencies which did not demand the same standards in respect of doctors, ranging from their ability to speak different languages through to experience of medical treatment. In consequence, we now have a troubling kind of medical roulette where a great deal depends on whether you get ill on Thursday or on Friday. The statistics are quite frightening, showing not a narrow but a very substantial difference.

Before the noble Lord, Lord Hunt, comes in-if he does-and before the Minister responds, I would like to raise two points. The first is about the degree to which the noble Lord believes we can begin to re-establish out of hours work to a higher level of quality broadly equivalent to that offered by general practitioners and other medical

staff to patients who conveniently fall ill on Monday through Friday but not later or after that. Secondly, what does the Minister feel about the dependence of some groups in our community on emergency services, not because they want to use them but because they are not familiar with ways to establish their proper relationship with people who could look after them in difficult conditions? This goes back to one of the particular concerns of the noble Baroness, Lady Finlay, which is the impact of alcoholism on emergency entry. This is not just another amendment; it is a crucial one which points to a very troubling discrepancy which could grow worse if we do not succeed in addressing it.

Lord Walton of Detchant: My Lords, it would be difficult to overstress the crucial importance of this issue, which has been a matter of grave concern to the specialist medical community. People with less common conditions often require specialist services for treatment unavailable through generic NHS support. At Question Time today, I posed a Question to the Minister about the report of the National Audit Committee which had demonstrated the serious inequalities of neurological services throughout the United Kingdom. People with neurological conditions rely not only on skilled neurologists but on a specialist multi-disciplinary team of nurses, physiotherapists, occupational therapists, speech and language therapists and others to maximise their independence and quality of life. The Bill proposes that these services be commissioned at a local level by Clinical Commissioning Groups which will be able to determine the size of the population for which they have responsibility and which, as matters stand, will have no duty to collaborate with other Clinical Commissioning Groups in the commissioning of services. Grave anxieties have been expressed by the Rare Disease Consortium and by the Neurological Alliance which is the only collective voice for more than 70 national and regional brain, spine and neuromuscular organisations working together to make life better for 8 million children, young people and adults in England with a neurological condition.

My personal wish would be to ensure that the commissioning of highly specialised services and services for less common conditions was conducted by the national Commissioning Board and not delegated to local clinical groups. After all, many of those clinical commissioning groups will cover a relatively small population area, and a lack of specific monitoring of this issue by the NHS Commissioning Board could allow geographical disparities in service provision and outcome-disparities that already exist and are serious-to widen.

At an earlier stage in the debates on the Bill, I mentioned my interest in research into muscular dystrophy and pointed out that when I started work in that field a boy with the most severe form of muscular dystrophy, Duchenne-type dystrophy, would have

difficulty in walking in childhood, would be confined to a wheelchair, and would usually die at about 16 years of age from respiratory insufficiency. A recent major investigation by an All-Party Group studying facilities for the management of such patients throughout the UK demonstrated that in centres of excellence such as parts of London, Oxford, Newcastle and Oswestry boys with this disease are now living with supportive care and respiratory support into their 30s and even their 40s, and living much more productive lives. In some parts of the United Kingdom, such as the east of England and the south-west, we found that such boys were still dying in their teens. That is just one example. There are many other rare diseases where new developments in genomic medicine are resulting in the discovery of new forms of treatment.

I well remember-I am talking about the role of general practitioners-two GPs telling me that they thought it was quite disgraceful that I was spending time and effort in raising money for research into and treatment of a rare disease such as muscular dystrophy, which after all, they said, was a fatal condition and the money could be much better spent on the management of common conditions. I am very concerned that some of the clinical commissioning groups would not take full account of the crucial needs of people with rare, crippling and progressive diseases. After all, I have often said that you cannot measure human suffering in purely numerical terms. It is a matter of great importance, and for that reason these amendments are crucial in order to make certain that rare diseases and uncommon conditions are fully accepted as being of great importance, and that the commissioning of services for them will be a vital part of the provisions in the Bill.

Lord Warner: My Lords, I rise briefly to lend my support to Amendment 64ZA in the names of the noble Baroness, Lady Finlay of Llandaff, and my noble friend Lord Hunt. I do so on the basis of my experience as chairman of the provider agency in London after my time as a Minister. We have seen in London how strategic leadership at the level of, in this case, the strategic health authority has transformed stroke services and A&E and trauma services. There is no doubt, based on the London experience, that these kinds of changes will not be engineered at the local level. They require populations of considerable size, particularly when we are living in the era of the European working time directive and its effect on the rostering of specialist services and clinicians, to produce the kind of quality of service that people need.

There is often a kind of conflict between that strategic leadership and the wishes of people at the local level putting pressure, if I may put it that way, on their local doctors to keep services very local. I accept that the Government wish to have a lot of this decision-making down at the local level, but we have to recognise that there is

sometimes a conflict between that localism and planning in the area of emergency services as regards the most effective way of providing high-quality services to patients.

The Minister therefore needs to listen to concerns such as those that the noble Baroness, Lady Finlay, was expressing, because we know from the evidence in London that these kinds of services need to be planned at a major-population level.

Baroness Morgan of Drefelin: My Lords, I rise briefly to support Amendment 50A in the name of the noble Baroness, Lady Finlay, and the noble Lord, Lord Patel, and Amendment 63A in the name of the noble Baroness, Lady Finlay. We need to be clear that the role of NICE in our health system is extremely important. It plays a pivotal role in helping the system to understand innovation, and it is extremely important in promoting fairness. At a time of very tight resources, it would be good to have the role of NICE clearly set out in the Bill. I know that the noble Baroness, Lady Finlay, talked about the reputation of NICE and the role that it plays in facilitating audit and many other things. For me, however, it is about making sure that we have fairness across the NHS in England, and NICE is key in ensuring that that happens for patients.

I want to comment briefly on Amendment 63A. Others have talked about the concerns of the Neurological Alliance. I speak as the honorary President of Cancer52, which represents people affected by rare cancers. The majority of cancer deaths in this country occur because of rare cancers. We know that if a person is diagnosed with a rare cancer, they have often had to really fight through the system, visiting GPs many more times than those with the more common cancers which people call the "big four". Oesophageal, pancreatic and ovarian cancer, for example, are conditions of which GPs have very little experience. There is a great deal to be done in the NHS to improve outcomes for people diagnosed with what are often called less common or rarer cancers, but which are a group of conditions which account for more than 50 per cent of all cancer deaths. The noble Baroness, Lady Finlay, is right to say that we should be encouraging commissioners to ensure that, where rare conditions are concerned, there is collaboration and knowledge and experience sharing so that they do the right things for patients, regardless of how common their condition may be.

Baroness Jolly: My Lords, I had not intended to speak because everything had been said. However, the noble Lord, Lord Walton of Detchant, made a point that I think is worth picking up on. I declare an interest as Chairman of the Specialised Healthcare Alliance which works with people with rare and complex conditions. These conditions are commissioned by the NHS Commissioning Board, while the conditions referred to by the noble Baroness, Lady Finlay, in Amendment 63A are intended to be commissioned by CCGs. Clearly, people are really anxious about these commissioning arrangements. They are based on geography; they are relatively small in number, but not tiny; they are

geographically sparse; and very often GPs will not actually see these conditions very frequently.

The noble Lord, Lord Walton, asked whether any thought had been given to sweeping these conditions in with the rare and complex conditions, and to have them commissioned by the NHS Board. I am not suggesting whether this is a good or a bad thing, but I think that those with these conditions and the organisations that represent them might be glad to engage in a dialogue on this to see whether it is the appropriate way forward. There is certainly a lot of anxiety about what is currently happening. If my noble friend would give us some indication of whether that could be looked at, that might alleviate some concern.

Lord Winston: My Lords, I hope that in summing up the Minister will address the general issue of genetic disease. The noble Lord, Lord Walton, referred to one specific single gene defect but there are some 6,000 single gene defects and they are often very complex. Most of them are fatal diseases and many of them affect children. A few sufferers of single gene defects live to a young age and some occasionally live into middle age. However, one problem that we already find in the health service is that provision for the care, treatment and diagnosis of these patients and for the counselling of their families is often very deficient, depending very much on whether funding is available.

An example is the work that has been going on in pre-implantation genetic diagnosis, which can prevent a child who might die from one of these diseases being born through the selection of a suitable embryo. Of course, this is not a cheap procedure but in terms of financial efficiency for the health service it is very much less expensive than the complex care that might be involved for a child with, for example, advanced male-type muscular dystrophy. Hitherto there has been a huge difficulty in getting these services through individual PCTs because they think in the short term and are on a budget from year to year. Therefore, collaboration seems extremely important not only in relation to these rare cancers, which of course are immensely important, but for a great number of diseases which are extremely distressing. I am sure that the Minister will fully understand and be greatly sympathetic to the fact that the families involved are immensely distressed by these diseases. They are often very puzzled that they may be carrying one of these gene defects and they find it very difficult to get answers to what are quite complex problems. There really does need to be proper provision for them through collaboration with other authorities.

Lord Turnberg: My Lords, I should like to comment on Amendment 64ZA. I am sorry to inflict yet another medical opinion on the House but there is one factor which has not been mentioned in the planning of emergency services-that is, the fact that the vast

majority of patients in medical wards are admitted through the emergency department, coming in as acute emergencies. This is quite unlike the situation in surgical wards. They, too, have their ration of emergencies but the majority of patients are admitted from waiting lists, and this is where the waiting list initiative and so on come in. However, when planning for medical beds, one has to think in terms of the accident and emergency department being the major route by which these patients enter the hospital and, in planning for emergency services, one has to think of the bed needs associated with that.

Baroness Masham of Ilton: My Lords, I, too, support these amendments, being associated with the rarer cancers group and various other groups. I had a cousin who had neuroblastoma two years ago and had to go to America for treatment. Some of these problems are really complex and GPs have never seen them. However, in the longer term, it is a question of ongoing treatment and the complexity of getting the right drugs for the right condition. Sometimes these drugs do not even come before NICE because the conditions are so rare. This matter really does need serious consideration and I hope that the Minister will do his best.

Lord Patel: My Lords, my name is added to Amendment 50A and I rise only to say that my silence thus far does not mean that I do not approve of the amendment. I strongly support it. There is a saying that if you get six doctors in a room, you will get six opinions, but I do not think that that will be the case today. The key point of the whole debate is that in the management of patients with rare conditions NICE guidelines are followed. If that is done in the commissioning of the care of patients with rare diseases they will get quality care.

Lord Hunt of Kings Heath: My Lords, this is a useful debate and I hope that the noble Earl, Lord Howe, will be able to describe how he thinks specialist services and services for less common conditions will be protected in the new arrangements.

We know that there have been problems with the current commissioning arrangements by primary care trusts, the issue being that if they are dealing with services that cover only a small group of patients they do not have the experience or expertise to commission services effectively. The possibility exists that clinical commissioning groups that cover even smaller areas than PCTs will have the same challenges to face. We know that the NHS Commissioning Board will be commissioning some services at a national level. It would be helpful if the noble Earl, Lord Howe, could explain the distinction between those services that will be deemed to be of national importance but there is clearly concern that CCGs will not be able to have the critical mass to commission locally, and so they fall to be commissioned nationally. Where will the line be drawn?

There is a powerful case for highly specialist services and those that are known as services for less common conditions to be given some protection in the system.

Amendment 64ZA is rather different but it comes back to the point raised by my noble friend Lord Walton in our debates in Committee on the need for strategic direction on reconfiguration issues. I am sure that he is right, as indeed was the noble Baroness, Lady Finlay, to point out that decisions on emergency care and specialist networks are very difficult to make. We know that we probably have too many hospitals providing emergency care at the moment, but we also know that it has often been very difficult to reach local consensus. I know that the thrust of the Government's legislation is for local determination but that is asking a lot. If you take a region you are asking for a huge number of clinical commissioning groups to come together and sign up to some kind of reconfiguration process which would lead to a more integrated approach in relation to emergency care. Without strategic health authorities and unless the local outposts of the national Commissioning Board are actually going to take an assertive role, there is a risk that we will not have the mechanism for making the kind of hard decisions that need to be made.

I am convinced that some strong, national leadership is required if you are to get movement on better emergency care and an acceptance that the current arrangements in some parts of the country simply will not do. It is interesting to see the debate in Mid Staffordshire following the problems in that trust and the recent publication of letters sent by the local clinical commissioning groups about the future of that hospital, causing a furore in the area. It shows some of the problems of an individual clinical commissioning group seeking to come to a view about the kind of reconfiguration of acute services. Of course, CCGs will need an input, but some external view and leadership would be very helpful to enable us to get better provision of services. As my noble friend Lord Walton says, one of the best examples of this is in relation to stroke services. The experience in London has shown, without any doubt, that pooling stroke services together in a limited number of acute centres has led to hugely enhanced outcomes. As a result of the London experience the strategic health authorities are requiring the same to be done throughout the rest of the country. The question I put to the noble Earl, Lord Howe, is: under the arrangements in the Bill, how can we ensure that that kind of national leadership will continue?

Earl Howe: My Lords, this has been another excellent debate. It is worth saying at the outset that I fully appreciate the importance of the board and CCGs paying due attention to the way they commission specialised services and services for less common conditions and indeed emergency services. I fully endorse the importance of services being delivered in an integrated way when that is in the best interests of patients. I

listened very carefully to the case put forward by the noble Baroness, Lady Finlay, on Amendment 50A. She made a very persuasive case about the importance of only ever commissioning specialised services with a close acquaintance with the relevant guidance and evidence base. I could not agree more with her on that. Commissioning of specialised services requires specialist skills and this is precisely why we feel that the Commissioning Board is the right body to commission such services. The board will be able to draw on a great deal of expertise in doing so. I hope the noble Baroness recognises our shared commitment in this area. Very shortly we will be publishing a consultation document as a UK response to the EC recommendation on rare diseases. We hope to be able to do that within a few days. The consultation document and responses will form the basis of the UK's plan. She will see in it that a great deal of thinking is going into how these services should be commissioned.

The noble Lord, Lord Walton, spoke with his customary authority about Duchenne muscular dystrophy. He may like to know that all regional specialised commissioning groups have undertaken reviews of neuromuscular services in their localities. Improvements to services are already being put in place. For example the NHS has invested in care co-ordinator posts which can reduce emergency admissions and readmissions. The national specialised commissioning group has also included neuromuscular disease as a priority in its 2012 work plans and it has been looking at emergency admissions as part of that work.

The noble Lord, Lord Winston, referred to rarer conditions, including those of genetic origins, as did the noble Baroness, Lady Masham, in relation to neuroblastoma. I identified closely with all that they said. Many of these conditions are extremely rare fortunately. It is not possible for all health professionals and carers to have detailed knowledge of conditions which they will see only very rarely in their working life. However, already we are addressing this through such initiatives as NHS Choices. It is one of a number of initiatives we have developed to provide comprehensive, clinically accredited information about health and health services. Comprehensive information to support clinical decision-making is also included on NHS Evidence, the new web-based portal hosted by the National Institute for Health and Clinical Excellence. It provides access to a range of information, including primary research literature, practical implementation tools and guidelines. I am not suggesting it is the total answer to this conundrum but it is certainly a demonstration of the direction of travel. We want to see much more information available to commissioners at a local level.

I think there has been consensus in this debate as to the need to think long and hard about how and at what level particular services should be commissioned. I completely agree with that. It is not always clear cut and it does require careful thought. The Bill says that certain services will be for the board alone to commission. We expect these to include certain highly specialised services-I direct that assurance particularly to the noble Lord, Lord Walton. Other services will be by and large for CCGs to commission, but in collaboration if need be with other CCGs and supported by the board.

I appreciate the keenness of the noble Baroness, Lady Finlay, to ensure that the board's commissioning of highly specialised services pays due regard to NICE guidance. However, we would prefer not to impose a blanket requirement on the board to exercise its functions in respect of specialised services, or any of its commissioning functions, in accordance with NICE guidance. NICE guidance will undoubtedly be relevant to specialised commissioning-that is obvious-but the amendment could well have the effect of requiring the board to have regard to it at the expense of other authoritative sources of advice. I have already referred to a couple. In exercising its duty to obtain expert advice, we would expect the board to draw on as wide a range of professional expertise as possible and not be constrained into prioritising that of NICE, valuable though that would be.
It is important for us to remember that CCGs must be competent to commission all services to meet the reasonable needs of all those for whom they are responsible. This includes services to meet the needs of patients with "less common" conditions, as Amendment 63A points out. CCGs will need to be well supported in developing as commissioners and the Bill provides a framework for just that. It provides for collaborative working, in Section 14Z1, between CCGs. The NHS Commissioning Board must publish guidance on commissioning, to which the CCG must have regard, which could also cover issues relating to commissioning for less common conditions.

The clinical senates and networks will be overseen by the board to ensure that CCGs can access specialist advice. Clinical commissioning, by giving responsibility for ensuring services meet the reasonable needs of patients to the very clinicians who deal with those patients daily and understand their needs, provides a far stronger basis for ensuring that commissioning caters to the needs of those with less common conditions than the current commissioning arrangements. GPs will be able through their membership of the CCG to seek to ensure that commissioning takes account of the less common conditions, which might not be of great significance across an entire geography but which are of great concern at the level of the individual GP practice.

I can assure the noble Baroness that the NHS Commissioning Board will be required to have a robust authorisation process to ensure that CCGs have made appropriate

arrangements to discharge their functions competently, including consideration of the extent to which CCGs have collaborative arrangements for commissioning with other CCGs or local authorities as well as any appropriate commissioning support.

However, while I completely recognise the importance of commissioning services for this particular group of patients, I am afraid that I would prefer not to single out a requirement for authorisation to look at specific groups of conditions in the Bill. It would not make the NHS Commissioning Board's process any more effective, but it might lead emerging CCGs to add undue weight to this if it was the only part of the services that CCGs will be responsible for commissioning that was specified in relation to the authorisation process.

I hope it is recognised by your Lordships that in opposing Amendment 64ZA I do not wish to suggest that the concerns of that amendment, to ensure the quality of urgent and emergency care and the integration of its different elements to the benefit of patients, are unimportant-indeed, quite the opposite. The framework in the Bill for ensuring the competence of commissioners, securing continuous improvement in the quality of care and ensuring the promotion of integration applies to emergency and urgent care services every bit as much to as other areas of care. Commissioners will use the expert advice from senates and networks, and from other sources, to determine the best approach to commissioning integrated approaches to the delivery of urgent and emergency care, and within the context of a far-reaching national programme. As the House will know, we already recognise the importance of integration across the health service, particularly in urgent and emergency care. The introduction of NHS 111 will act as a driver for the redesign of local urgent and emergency care systems to create a more integrated system that is easier for patients to access and understand.

I understand the noble Baroness's concerns about competition in the context of emergency care and I should like to reassure her on that issue. We have been clear that competition should be used only where it is in the best interests of patients. For some services or parts of a pathway this may not be the case and commissioners will need to use their judgment as to what is in the interests of their patients and whether competitive tendering is appropriate. With some services, such as emergency care, it is surely highly unlikely that this test would be met. Indeed, we have always cited A&E as a prime example of where choice is usually irrelevant and competition will almost certainly be inappropriate.

I was asked by the noble Lord, Lord Warner, and the noble Baroness, Lady Finlay, about what will happen in the future to cater for the kind of reconfiguration of services that we have seen in London and how the new system will support a regional style of planning. Section 14Z1 enables CCGs to collaborate, as I have already said, in respect of the

exercise of their commissioning functions. That is of particular relevance in the context of emergency care. In the same way as current PCTs operate, CCGs may choose to act collectively to co-ordinate care over larger geographical areas; for instance by adopting a lead commissioner model to negotiate and monitor contracts with urgent care providers. In instances such as that, I am sure that the strategic advice of clinical senates and the range of expertise of clinical networks will prove invaluable in continuously improving the quality of services and care for patients.

The noble Lord, Lord Hunt, spoke of the need for external expertise in this kind of decision-making. I agree with him. That will be essential in some cases. The clinical senates will be available as a source of specialist and strategic advice to health and wellbeing boards, in particular, providing a link between professionals and national leadership, although it is anticipated that senates are only likely to become involved in service changes or other issues occurring on a significant scale. However, very often emergency services will be on a significant scale.

My noble friend Lady Williams asked about improving out-of-hours services. We are taking work forward already on that front. Improvement of out-of-hours care will be taken forward as part of the development of a coherent 24/7 urgent care service. Two of the aims of this provision are, first, consistent high-quality integrated care led by clinical commissioning groups, delivering the best outcomes and experience 24/7, with no noticeable differences during or out of normal office hours; and, secondly, greater integration, with services working together to provide a seamless service irrespective of the provider organisations which operate them.

Our vision for urgent care is to replace the ad hoc unco-ordinated system that has developed over the past 13 years-which has been characterised, I am afraid, by poor quality and too much variation-with a system that patients better understand and can get them to the right place first time. Amendment 64ZA would not stimulate that. In fact, it could well distort the local freedoms which commissioners need to develop the best and most effective integration of care.

I hope that I have said enough to persuade the noble Baroness to withdraw her amendment.

Baroness Finlay of Llandaff: I am most grateful to the Minister and to everyone who has spoken in this debate. There has been widespread support around the House for this group of amendments. The Minister's comments on NICE were reassuring and very helpful. We will be returning to less common conditions in relation to clinical commissioning groups, but I feel that we have teased out the very difficult dilemma of

the duties that sit with the Commissioning Board versus those that sit with the local clinical commissioning group and how that division and integration work.

Again, in terms of emergency care, the Minister has made very many helpful comments. However, I do have some concerns that I would like to consult on. It would be really helpful if he would meet me and some people from emergency medicine. The College of Emergency Medicine has been trying very hard to work with the Government to make sure that this Bill actually does enhance and does not damage inadvertently the improvements in emergency care that it has been driving across the country very fast over recent years. A meeting would be most helpful. Pending such a meeting, I will withdraw the amendment for the moment, but we may need to come back to some of this at Third Reading, so I would like to reserve that. I beg leave to withdraw the amendment.

Amendment 50A withdrawn.

Amendment 51 had been withdrawn from the Marshalled List.

Amendment 52 not moved.

Amendments 53 and 54

Moved by ***Earl Howe***

53: Clause 22, page 18, line 17, leave out from "must" to end of line 18 and insert "have regard to the desirability of securing, so far as consistent with the interests of the health service-"

54: Clause 22, page 18, line 23, at end insert-

"( ) If, in the case of any exercise of functions, the Board considers that there is a conflict between the matters mentioned in subsection (1) and the discharge by the Board of its duties under sections 1(1) and 1G(3)(b), the Board must give priority to those duties."

Amendments 53 and 54 agreed.

Amendment 55 not moved.

Amendment 56

Moved by ***Earl Howe***

56: Clause 22, page 18, line 34, leave out from "decisions" to end of line and insert "which relate to-

(a) the prevention or diagnosis of illness in the patients, or

(b) their care or treatment."

Amendment 56 agreed.

Amendment 57

Moved by ***Baroness Finlay of Llandaff***

57: Clause 22, page 18, line 39, at end insert-

"( ) The National Commissioning Board must have regard to advice from a range of healthcare practitioners from across the patient pathway, including local clinical specialists and allied health professionals."

Baroness Finlay of Llandaff: My Lords, this is another group of amendments that relate to the process of commissioning. Their aim is to ensure that commissioners have regard to all the expert advice needed to make informed decisions about commissioning services for patients, particularly complex services that operate across the care pathway. Amendment 65, which is primarily in the name of my noble friend Lord Patel, further aims to ensure that safety information is shared with everybody who needs to know about it.

The groups of particular concern to be consulted go beyond medicine and nursing; the wording in the amendment is "local clinical specialists". They will be linked to their own specialist group and specialist society and will be expected to be completely up to date with advances in their field, enabling the most modern, up-to-date and cost-effective care to be brought down to a local level. They also address allied health professionals.

We have spoken remarkably little about the contribution of allied health professionals in our debates so far, and they have not featured on the face of the Bill. Physiotherapists form the largest group of allied health professionals. I declare an interest as president of the Chartered Society of Physiotherapy. As a group, they are very used to representing other allied health professionals; and, as a group , allied health professionals are very used to understanding the role and contribution of each other, such as occupational therapists, speech and language therapists and so on, groups that are small in number but have a very important contribution to make. One of the reasons that they become

so important in these new processes of a care pathway is that, if we are expecting more patients to be looked after in the community, we have to do a great deal to increase the independence of individuals.

The physiotherapists and occupational therapists are par excellence the people who will maintain or re-establish mobility and be able to discharge patients from hospital. I know from my own clinical practice that all too often we are waiting for the physio or the OT to provide the essential input that makes the difference between a patient remaining an in-patient or being able to get home, particularly where they have mobility problems. Physiotherapists also have a role in mental health and can be very important in establishing mental health improvements as well as just physical health. It is with that background that they have been featured in these amendments as a group of allied health professionals, because, sadly, many doctors and nurses do not really understand the major and very cost-effective contribution that these healthcare professionals can make. I beg to move.

Lord Patel: My Lords, I shall speak to two amendments in my name, Amendments 65 and 66. They are very simple. They regard the information on the safety of services provided by the health service. I particularly want to address the issue about patient safety.

Amendment 65 refers to the information provided. The Bill says that the Commissioning Board will provide information to those whom it "considers appropriate". I do not know why the Commissioning Board must decide who it considers appropriate; my amendment merely lists all the organisations providing healthcare to whom the information must be provided. Patient safety incidents occur mainly because of systems failure. I can give many examples, from wrong-side surgery to wrong infusions, wrong medicines reconciliation and wrong injections in the wrong side-such as a spinal injection when a particular material must not be injected spinally. Because it is a system failure, if such a patient safety incident occurs in one hospital, it is likely to occur in another. So the information must be provided to all healthcare providers and those who train doctors and nurses. I do not understand why it must be that the board must make information collected on patient safety incidents available only to those whom it "considers appropriate".

My next amendment has to do with subsection (3), which says:

"The Board may impose charges, calculated on such basis as it considers appropriate, in respect of information made available by it under subsection (2)".

Why must it charge? If it charges, we do not get the gains from the lessons learnt from patient safety incidents.

The two amendments are quite simple. I do not understand why it is not clearer.

Lord Turnberg: My Lords, my name is attached to two amendments in the group, Amendments 57 and 99. I shall speak very briefly. They are both about ensuring that, first, the commissioning board can put itself in the best possible position to develop its plans by having available to it all the advice that it can get. When the board makes its decisions it has to be able to show and demonstrate that it has reached those decisions on the best evidence possible. That is what the amendment tries to do. The same argument, only even more so, can be applied to CCGs. That is Amendment 99. They will certainly need all the help that they can get, and Amendment 99 gives them the opportunity to get the support that they need. I hope that those two amendments can be supported, at least.

Lord Warner: My Lords, I have added my name to Amendment 66 from the noble Lord, Lord Patel. Given all the hard work that has gone into trying to improve knowledge about medical and other areas, to improve patient safety, it seems extraordinary that in this Bill there is a provision to enable the national Commissioning Board to be able to charge for information about patient safety defects that have come to its attention. That seems pretty bizarre, but no doubt there is some explanation in Richmond House that would convince me. I look forward eagerly to knowing what it is.

Baroness Morgan of Drefelin: I follow on from the comments of the noble Lord, Lord Turnberg, and will speak to Amendments 99 and 100. There has been a great deal of debate in Committee and now at Report about the duties of the new clinical commissioning groups and how the commissioning of health services should be improved. I will briefly expand on some of the points that have been made in previous debates on this subject.

We know that the commissioning of cancer services could often be better. I remind the House again of my interests in this matter. It is crucial that a range of experts are involved in commissioning. As the noble Lord, Lord Turnberg, has just said, they will need all the help they can get. It is crucial that expertise is used and sought, for example from people operating within the many cancer networks that currently do such an excellent job in supporting cancer commissioning.

I welcome new duty on clinical commissioning groups provided by new Section 14V, which commands that they will need to obtain appropriate advice from professionals with a broad range of expertise in the prevention, diagnosis or treatment of illness. The

noble Baroness, Lady Finlay, has tabled an amendment which slightly expands on that duty and mentions the need for expertise in the whole of the patient pathway. That amendment is interesting as well.

I also believe that clinical commissioning groups, during their authorisation process and annual review, should be required to demonstrate how and where they obtain advice to commission cancer services. This would be a very important point of transparency. Ideally this should include, for example, a cancer lead in each clinical commissioning group who is responsible for liaising with the clinical networks and local authorities to ensure a coordinated approach to commissioning cancer services across the pathway.

I should like to ask the Minister two brief questions concerning clinical commissioning groups' new duty to obtain appropriate advice. First, could he update the House on how the Government will monitor the implementation of this crucial new duty? How will clinical commissioning groups be required to report on it, and at what level of detail? Will it, as I mentioned, include named leads, and how will these reports be monitored? Secondly, what steps will be taken if a clinical commissioning group fails to fulfill this crucial duty, and by whom will these steps be taken? The role of cancer networks and the expertise that they bring to bear is key. That should not be lost through this process.

Baroness Masham of Ilton: My Lords, I have put my name to Amendment 99. Will the Minister tell the House a bit more about the clinical senates? He has spoken about them previously but it would be interesting to hear a bit more about who will actually be on them, who will pay for them and how will they give their information. There are many people, especially in the cancer field, who would like to know more.

Baroness Wheeler: My Lords, we strongly support the amendments in this group, which underline the importance of the NHS Commissioning Board and CCGs seeking advice from healthcare practitioners from across the patient care pathway, including local clinical specialists and allied health professionals, and going beyond professional input to seek advice from organisations with expertise in the experience of patients.

We hope that the Government will recognise the strong case put forward by the noble Baroness, Lady Finlay, and other speakers to these amendments for also recognising the expertise of patients' organisations in the Bill and ensure that commissioners seek their advice as well as that of health professionals. By this we mean patients' organisations not just being consulted but beinggenuinely involved in helping to co-design or co-produce services. Many patients' organizations, such as the Stroke Association for example, arekey providers of local services such as reablement or information, advice and support services to stroke survivors, carersand family members across the country. They have first-hand, direct experience of the issuesthat matter most to patients across

the whole care pathway, hospital and community. Involvement of patient groups would also help the patient voice in the clinical senates and networks, which the noble Baroness, Lady Masham, also mentioned. To remind the Government, this approach was supported by the clinical workstream of the Future Forum, round one, but was overlooked in the Government's response. Now is a good opportunity to address this issue.

Amendment 65, tabled by the noble Lord, Lord Patel, and the noble Baroness, Lady Finlay, deals with information collected by the board on the safety of services provided by the health service being made available to healthcare providers, the Care Quality Commission and HealthWatch England, local authorities and professional organisations in healthcare. We fully support this, along with the caveat provided by Amendment 66 that the information should be freely available without charge. I hope that the Minister will accept the need to make progress on this important issue and reassure the House about the involvement of healthcare professionals and patient organisations in developing the commissioning plans.

Earl Howe: My Lords, this has been an interesting and worthwhile debate and I appreciate the concern that the noble Baroness, Lady Finlay, and other noble Lords have demonstrated throughout the Bill's proceedings to ensure that the board and CCGs benefit from as wide a range of advice as possible. The Government have been clear that everyone with a role to play in securing the best possible services for local people should be able to do so. The NHS Future Forum recommended that we strengthen the legislative duties to help achieve this, which is why the duties on the board and CCGs to obtain appropriate advice were strengthened in another place to incorporate the wording used to define the comprehensive health service and to ensure that it was clear that such advice should come from persons who, taken together, have a broad range of professional expertise.

I mentioned clinical senates on the last group of amendments. Of course we envisage a role for clinical senates in the arrangements for how these duties are fulfilled, providing not just clinical but multidisciplinary advice from professionals from public health and social care alongside patient and public representation and other groups as appropriate. The noble Baroness, Lady Masham, asked me specifically about clinical senates. They will be established as strategic advisory bodies, with a clear focus on quality improvement and improving outcomes. They will bring together clinicians with strong clinical credibility, drawn from across the disciplines, as I have mentioned. They will include patients and members of the public as well. They will have a role, too, in advancing public understanding of health and healthcare.

Why do we need clinical senates? Commissioning is at its best when it is a collaboration of professionals, based on a shared drive for continuous quality improvement. Maximum participation will be key here. The Future Forum report showed:

"There was universal agreement that people would be",better served if their,

> "care were designed around their needs and based on the input of the public, patients and carers, health and social care professionals",

the voluntary sector, "and specialist societies". The exact detail of who will be part of the clinical senates, the number that will exist and the roles that they may have are all to be determined through a process of discussion and engagement, but I hope that I have outlined, at least in broad terms, what they will be there to do.

Baroness Masham of Ilton: Who will pay for them?

Earl Howe: My Lords, they will come under the aegis of the NHS Commissioning Board. They will be part of the board.

Having said all that, I remain unconvinced that imposing specific duties as to where advice should come from, including specifying particular sources of advice such as in Amendments 57 and 99, is the right way forward. I am afraid that if we were to do that, there would be then justifiable demands to include in the Bill other clinicians and groups of people who commissioners should seek advice from when exercising this duty. My view is that this is horses for courses, and that it is appropriate that the board and CCGs should have the freedom to determine what advice it is appropriate to seek in each instance. That is why the emphasis in the duties as they stand is rightly placed on ensuring that the commissioner obtains "appropriate advice" from people with a broad range of professional expertise. It is that breadth of expertise which is important, not the particular professionals involved.

Amendments 58 and 100 are admirable, if I may say so, in that they seek to require that the advice should come from across the care pathway. I have every sympathy with the noble Baroness's intentions there. Again, however, I think that this is already provided for in the duty which-in its reference to expertise in the prevention, diagnosis, or treatment of illness, and the need to obtain advice from persons who, taken together, have a broad range of professional expertise-is designed to be of maximum scope, and I am confident that it will be interpreted as such.

We have also just discussed the important role that both patients, and the organisations that represent their interests, can bring to the commissioning process. However, I think

that Amendments 59 and 101 are unnecessary. Let us be clear that while these duties refer to obtaining advice from people with expertise in relation to the health service, this is not confined to clinical expertise. There is nothing to prevent the board or CCGs securing advice from patients' organisations, or those with expertise in the patient experience. The board can also draw on the advice of national and local healthwatch as a conduit for such advice. CCGs, similarly, are able to draw on the advice of local healthwatch.

However, to reiterate the point that I made in Committee, there is a risk in becoming too prescriptive. In reality, we have to trust them to build these relationships themselves and judge them on the outcomes that they achieve. If we commission for good outcomes, we will, as night follows day, secure the appropriate knowledge and advice to enable us to do that.

It will also be an important part of the board's remit to produce advice and guidance to prevent the recurrence of incidents that jeopardise patient safety, just as the National Patient Safety Agency does now. It is important that the board is able to share relevant information relating to patient safety. The noble Lord, Lord Patel, is absolutely right that information that can inform and enhance patient safety in the NHS should be made available to all those who would benefit from it. The NPSA, as he will know, currently shares this information with a number of bodies with a particular role in relation to patient safety-for example, the MHRA and the CQC-and this will continue to be the case. Indeed, if it did not make important information available to those who it thought could reasonably benefit from it, the board would be in breach of its duty.

In addition to NHS bodies, this information is currently also used to develop products for use by non-NHS organisations, by the devolved Administrations and international organisations, for which the board may determine it appropriate to charge a fee. It is for those reasons that we have framed the duty to share information in broad terms, and we would not want to be more prescriptive in the way that Amendment 65 proposes. Neither would we want to prevent the board charging a fee when appropriate, as would be the effect of Amendment 66. I think that it is reasonable for the board to determine how and in what circumstances it may impose charges for the information it provides. The power is intended to allow the board to seek adequate compensation for the services that it provides to other bodies where there would otherwise be no benefit to the health service. However, there is no scope for the board to charge for the advice and guidance that it would be required to provide for the purpose of maintaining and improving patient safety, and although there is provision for the board to impose charges, Clause 22, which inserts new Section 13Q(4), makes it clear that the board must

give, not sell, advice and guidance to appropriate bodies to maintain and improve the safety of the health service. I hope that that is reassuring to noble Lords.

The noble Baroness, Lady Morgan, asked me about the monitoring of advice and what happens if they fail on that duty. CCGs will have an annual performance assessment by the board, which would assess how well they discharge their functions, including this duty to obtain advice. If a CCG fails to perform any of its functions, effectively the board can intervene and can take action. I hope that the clarification I have given is helpful and that I have sufficiently reassured noble Lords to enable them to withdraw their Amendments 57, 58, 59, 65 and 66.

Amendments 72 and 115 in my name clarify the circumstances in which the board of CCGs must consider common-law confidentiality requirements when considering whether or not to disclose information. We have listened to the views expressed by my noble friend Lord Marks, the noble Lord, Lord Harris of Haringey, and the BMA; they drew attention to circumstances where, if common law did not apply, there was the potential for disclosure to threaten patient confidentiality. We are therefore bringing forward these amendments to achieve what we believe is an appropriate balance between ensuring that information is disclosed when appropriate and protecting personal confidential information. The amendments are tabled in my name to achieve this, and I hope that they will receive the support of the House.

Baroness Finlay of Llandaff: My Lords, I am grateful to the Minister for having listened so carefully to the amendments and for having addressed and recognised the real concerns that are behind the way that they were written and drafted. I rather hoped that he was going to say that the spirit of the amendments would be taken forward in guidance for commissioning as it is written, and I pose that as a very brief question to him before completing my comments.

Earl Howe: Certainly, my Lords. The spirit of the amendments will be incorporated in guidance.

Baroness Finlay of Llandaff: I thank the Minister very much. I beg leave to withdraw the amendment.
Amendment 57 withdrawn.

Amendments 58 and 59 not moved.

Amendment 60

Moved by ***Earl Howe***

60: Clause 22, page 19, line 13, leave out "have regard to the need to"

Amendment 60 agreed.

Amendment 60A

Moved by ***Baroness Morgan of Drefelin***

60A: Clause 22, page 19, line 16, at end insert ", and

"(c) research supported by the health service for the purpose of protecting the public in England from disease or other dangers to health"

Baroness Morgan of Drefelin: My Lords, I shall speak also to Amendments 66AA and 67AA in my name. The amendments are all designed to ensure that we have a strong commitment to the research duty throughout the NHS that matches the aspiration and vision set out so clearly during the debates on this issue on Report. There have not been many elements of the Bill so far that have been welcomed and united the House quite so strongly as the Government's acceptance of the strengthening of the research duty placed on the Secretary of State, the NHS Commissioning Board and the clinical commissioning groups. As we know, that was met with universal support around the House. Once again for the record, I declare an interest as chief executive of a medical research charity, Breast Cancer Campaign, which is a proud member of the Association of Medical Research Charities. We have been one organisation among many calling for the research duty to be strengthened.

While amendments to strengthen the research duty were widely supported, the debate on the first day of Report when these amendments were discussed reiterated a critical issue that was also raised in Committee: the duties must be meaningful and must therefore be monitored. There must be monitoring mechanisms in place throughout the system to ensure that the research duty is not there in theory alone. For that reason, I was reassured to hear from the Minister that the Secretary of State would be expected to report on how he fulfils his statutory duty annually, that CCGs will need to demonstrate how they will exercise important functions, including the duty of research during the authorisation process, and that a CCG's commissioning plan and annual report will cover the exercise of the duty of all the CCG's functions. However, no mention was made during the debate of the NHS Commissioning Board being required to report back on its duties when reporting its annual plan and business plan. The purpose of Amendments 66AA and 67AA is to make sure that we really address this key matter. I admit to being a bit confused about the Government's position on reporting on duties. On the one hand, the research duties have quite rightly been strengthened

but, on the other hand, there is a notable reluctance to ensure that it is a priority and a requirement for the Commissioning Board to report back on the activity relating to this duty. We need to have that transparency, so that we can see the benefits of the duty percolating through the system.

The duty relating to research is now stronger in wording than the duty relating to inequalities, but the Government have decided to include their own amendment, adding inequalities to the list of duties on which the board will be required to report. They have chosen not to do likewise for research. While I welcome and support the requirement to report on inequalities, this new step by the Government has reinforced my concern over whether there are sufficient reporting mechanisms embedded in the new structures of the NHS to promote adequately the vision of a research-led NHS that has found such widespread support in this House.

If, as the Minister may respond, all duties should be reported back on, why have this subsection, which identifies and highlights specific duties, within the clause at all? We are looking at a case of first among equals when it comes to some of the duties that the board is required to fulfil. How are we to understand what differences this will bring in reporting requirements? I hope that the Minister can use the opportunity now, late as it is, to reassure me that research will be a priority for the Commissioning Board and that there will be explicit reference to research and to the board's plans in relation to it in the business plan and in the report.

Amendment 60A is to seek further clarity on what is to be understood by the term,

> "research on matters relevant to the Health Service".

My concern on this point is to ensure that the terminology used in the duty should be sufficiently comprehensive. For example, will the current wording require the NHS to enable research to occur, and to support it, as well as utilising the evidence from research that is available? Having discussed this with the noble Earl, I am confident that he will be able to reassure me on this point. I beg to move.

Lord Willis of Knaresborough: My Lords, I am eager to speak at this late hour. It seems that every time we talk about research it is always around 11 o'clock at night. The Minister and his minions must be planning something which we do not quite know about, but here we are. I support Amendments 66AA and 67AA standing in the name of the noble Baroness, Lady Morgan of Drefelin. Will my noble friend the Minister clarify the issue over the head of research at NIMR? At an early stage on Report, he clarified the duties of the Secretary of State and the commissioning groups, and how they will be reported. I think that is quite clear to the House. Speaking on behalf of the medical

research charities, one of which I chair, there is general agreement on and support for the Minister's general direction of travel. However, the Commissioning Board is a different issue altogether. The Minister was silent on that when he reported back but he indicated that it would be the role of the chief executive of NIMR, Dame Sally Davies, to prepare plans and report back on research. However, my understanding is that Dame Sally Davies has two specific jobs. On the one hand, she is the chief executive of NIMR and is therefore responsible for funding research proposals that come to the Department of Health. That is a very distinct role of looking after more than £1 billion of spend in this particular direction.

Her other role is that of Chief Medical Officer. In that role, I understand that she is responsible for organising, on behalf of the Department of Health, research programmes that deal with both public health and those areas of the health programme that require specialist research input. The Minister appeared to say earlier on Report that Dame Sally Davies would, in her role as the head of NIMR, report to the board on research. However, perhaps she will not report to the board on research; perhaps she has a separate reporting line to the Secretary of State or Parliament. In that case, I should very much like the Minister to clarify that role.

In conclusion, I strongly support the arguments of the noble Baroness, Lady Morgan of Drefelin, in making her point about cherry picking duties. Earlier today, in response to Amendment 38A, moved by the noble Baroness, Lady Masham, the Minister rightly said that we should not cherry pick particular conditions in order to report on them. However, that is exactly what is happening over the duties. A specific set of duties, of which the whole House is incredibly supportive, are laid down in the Bill. However, only certain ones must be included in an annual plan and reported on. There can be no duty more important than that of research. It is the one area in which we will get the very latest treatments to patients quicker and with better health outcomes, yet it is one of the areas that is regarded as less important than others. I hope that the Minister will be able to satisfy both the medical research charities and this House on those two issues.

Lord Turnberg: I strongly support the amendments in the name of the noble Baroness, Lady Morgan, and the words of the noble Lord, Lord Willis. It is almost churlish to return to the matter of research when we have heard such welcome words and support from the noble Earl on research in the Bill. However, as an ex-chairman of the Public Health Laboratory Service, it would be wrong for me not to comment on Amendment 60A, which seeks to have research supported in the health service for the purpose of protecting the public in England. It is in that area that we may have a specific problem because public health will be dealt with largely by the local authorities. It is unclear how local authority support for research will be kept within the context of the needs of the

country, and how that will work with the marvellous amendments that the noble Earl has tabled. Perhaps he will clarify how local authorities will be engaged in promoting research and how we will encourage them to do so.

Baroness Thornton: My Lords, I support this group of amendments from the noble Baroness, Lady Morgan, which call on the NHS Commissioning Board to promote research supported by the health service for the purpose of protecting the public from disease and other dangers to health. These amendments also include the need for the board's business plan to explain how it proposes to discharge its duty in respect of these issues to promote the NHS constitution and for the annual report, in particular, to contain an assessment of how effectively it has discharged this duty. We support these too.

The amendments underline the importance of embedding research in the NHS and we welcome the introduction of a research duty on the Commissioning Board and the intention to ensure that research is genuinely an integral part of the health service, as my noble friend, Lord Turnberg, and the noble Lord, Lord Willis, said. This is one part of the Bill which has genuinely been recognised and improved on by the Government. However, ensuring that the intention of their duty is clearly understood and sufficiently comprehensive is crucial. These amendments are designed to ensure this. Amendment 66A would ensure that there are clear commitments to research for which the board is accountable and Amendment 67AA requires the board to explain activity relating to the research duty. Both these provisions ensure that there are important monitoring mechanisms in place in the board's business plan and annual report. As the noble Baroness, Lady Morgan, has stressed, they address an apparent anomaly which requires the board to report on improvement in the quality of services and on public and patient involvement but not on research, as the noble Lord, Lord Willis, said. We hope that the Government will accept these amendments in that spirit.

Earl Howe: My Lords, we had a very positive debate on the importance of research at an earlier stage of Report. I was grateful to the noble Baroness, Lady Morgan, for the support she expressed for the changes the Government have made to the Bill. I am more than happy to respond to these amendments this evening. I sympathise and agree with the noble Baroness's championing of research in this Bill. She and my noble friend Lord Willis have been particularly vocal and well informed on this subject. Nevertheless, I am afraid I am reluctant to agree that the Bill needs yet more amendment. Having said that, I hope I can reassure the noble Baroness going forward.

On Amendment 60A, the duties on the Secretary of State, the board and CCGs to promote research and the powers to conduct research all apply to the health service in its widest sense. This encompasses both NHS and public health services under the 2006

Act. In relation to the board's duty in new Section 13L, the duty to promote research on matters relevant to the health service already covers public health protection. Public health protection is a function of the Secretary of State under Section 2A of the 2006 Act and therefore part of the health service.

There are also other clauses in the Bill that focus specifically on research into health protection. Clause 10 lists research and other steps for advancing knowledge and understanding as examples of action that the Secretary of State may take under his wider duty in relation to protecting public health. Public health and health protection in particular will, of course, be predominantly the responsibility of Public Health England rather than the board. It is not therefore necessary for the board's functions to cover such matters but there will, of course, be close working between them and there are powers under Clause 21 for the Secretary of State to arrange for other bodies, including the board, to undertake any of his public health functions if necessary.

Turning to Amendments 66AA and 67AA, we have had a number of debates about exactly what the board should give particular attention to in its annual business plan and its annual report. I would like to remind your Lordships that the board is already required to set out in these documents how it intends to exercise its functions including how it will meet the various duties placed on it under the Bill.

The Bill emphasises a very few key duties that the board must look at in particular in its business plan, annual report and performance assessments, and that CCGs must look at in their commissioning plans and annual reports. We feel that we have chosen the right duties in each instance. As to the board's and CCGs' annual reports, it is more important that they focus on the outcomes that have ultimately been achieved through the provision of services, rather than on the way in which those services are being delivered. On the whole, that is the distinction we have tried to draw.

My noble friend Lord Willis asked about Dame Sally Davies and her reporting lines. I am sure my noble friend will remember that I wrote to him on 17 November and briefly covered this point. In short, as he knows, the National Institute for Health Research is and will remain part of the Department of Health. Its budget is held centrally by the department. The Chief Medical Officer is and will remain responsible for the NIHR and its budget. In her capacity as Chief Scientific Adviser and head of the NIHR, she will report to Ministers and the Secretary of State, but she will be there to give advice to the NHS Commissioning Board if asked to do so on matters relating to research. Similarly, in her capacity as CMO, she reports directly to the Secretary of State, but will be there to provide advice to Public Health England. I hope that that is of help to my noble friend.

The noble Lord, Lord Turnberg, asked me how the local authority role in promoting research would be assisted and how that would manifest itself in practice. I should like to write a letter to him on that point because the planning on that is, if I can put it this way, work in progress and I hope that I will be able to tell the noble Lord a little more in writing in a few days' time.

Lord Willis of Knaresborough: Before he sits down, will my noble friend tell the House whether he has made it clear in his remarks that the chief executive of the Commissioning Board will not have a direct relationship in terms of research, and will not have responsibility that will, in fact, be with the Chief Scientific Officer-the head of the NIMR? If that is the case, how on earth will the Commissioning Board have a relationship with the commissioning groups in terms of their duty to promote research?

Earl Howe: My noble friend is not correct. The board will have a duty to promote research, and we have debated that point. What it will not have is the budget for the National Institute for Health Research, which is held centrally. I think that noble Lords have welcomed that because it will mean that that budget is held separately from the board's own budget. However, that does not absolve the NHS Commissioning Board from responsibility for promoting research. Indeed, it will do that and have responsibility in particular for ensuring that the health costs of research carried out in NHS establishments are covered under the various tariffs. That will be a major part of the board's work.

I hope that I have reassured the noble Baroness sufficiently to enable her to withdraw her amendments, but I should of course be happy to talk to her outside the Chamber if there remain points that she would like to raise with me.

Baroness Morgan of Drefelin: There is one matter on which I should be really grateful for the noble Earl's help. In his helpful response to this debate, he said that there will be some key duties on which the Commissioning Board will need to report in particular. Will he also remind us that the Commissioning Board should report on all its duties, because I am not feeling that reassured at the moment?

Earl Howe: I apologise to the noble Baroness. I thought I had made it clear that of course there will be a duty on the clinical commissioning groups to assure the board that they have fulfilled all their functions. We fully expect that research will be covered in that. These particular duties have been mentioned in the Bill only either because they are absolutely integral to the delivery of outcomes, or because they relate to a fundamental strand of accountability-namely, the duties to reduce inequalities, to improve the quality of services, and to promote public involvement and consultation. These really are central to everything that the board and CCGs will do. It is not because

there is any greater obligation on the board to comply with them than there is in respect of any of their other duties. The same applies to CCGs.

Baroness Morgan of Drefelin: I thank the Minister, not only for giving me double reassurance in this debate, but also for the work that I know he has done personally to ensure strengthening of the research duty in the Bill in the first place. I also thank all noble Lords who took part in this debate. I withdraw the amendment.

Amendment 60A withdrawn.

Amendment 61

Moved by ***Earl Howe***

61: Clause 22, page 19, line 16, at end insert-

"13LA Duty as to promoting education and training

The Board must, in exercising its functions, have regard to the need to promote education and training for the persons mentioned in section 1E(1) so as to assist the Secretary of State in the discharge of the duty under that section."

Amendment 61 agreed.

27 Feb 2012 : Column 1161

Amendments 62 to 63A not moved.

Amendment 64 had been withdrawn from the Marshalled List.

Amendment 64ZA not moved.

Amendment 64A

Moved by ***Lord Mawson***

64A: Clause 22, page 20, line 24, at end insert-

"13OA Duty to have regard to the voluntary and social enterprise sector

(1) In exercising its functions, the Board must, so far as it is consistent with the interests of the health service, act with a view to ensuring that competition does not disadvantage the voluntary and social enterprise sectors.

(2) The Board may take specific action to support the development, including capacity building, of the voluntary sector, social enterprises, co-operatives and mutuals as it considers appropriate.

(3) Any action the Board takes in subsection (2) shall only be such that a level playing field between providers is achieved and maintained, meaning that one sector of provision is not more disadvantaged than another and the relative benefits of each form of organisation can be taken into account."

Lord Mawson: My Lords, I shall also speak to Amendment 64B. Many fine words have been spoken by this and the previous Government about the important role that social enterprise and the voluntary sectors now need to play in our changing economy, particularly in the NHS. Indeed, on 25 January, the Prime Minister spoke to exactly this subject in the other place, and in 2010 Secretary of State Andrew Lansley said during a speech to the voluntary sector leaders that he was assisting in the creation of the,

> "largest social enterprise sector in the world".

Indeed, he said that it would mean opportunities for this sector,

> "at every stage in the process".

These are very fine words, with which I agree. These two amendments are intended to turn these aspirations into practice on the ground up and down this country, because it is simply not happening when one looks under the carpet and at the fine detail. Whatever we think the numbers produced by civil servants tell us, something quite different is happening on the ground in practice.

When this matter raised its head in Committee, I reminded your Lordships' House of our practical experience in Tower Hamlets, where the social enterprise the Bromley by Bow Centre-I declare an interest as its founder and president-had competed with a large multinational company to run a local health centre. Having invested many tens of thousands of pounds in the process, the centre lost the bid on cost.

Fair enough, one might say: that is life. Because I was conflicted at the time, I kept out of the process but, as soon as it had finished, I realised that a very large company had undercut the centre and come in at a price that was simply not sustainable for either it or the patients, and that the inexperienced procurement officers in the PCT had no idea about what they were dealing with in practice-they had never run a health centre. Lo and behold, very quickly the company was adding new variation orders to the contract to up its value, and by year 3 asking to be relieved of its responsibilities under the contract.

The centre now runs the service, having wasted a great deal of money as a charity in the application process. The company was good to deal with, but the process was hopeless. One can imagine the messiness this contractual process created in a local housing estate which had had poor health provision for years, because in practice the local GPs were not held accountable. This was not good for patients and it was certainly not good for business.

11 pm

I recognise that this first amendment has limitations as to what it can achieve in practice but, because I am not allowed under competition law to put down an amendment that guarantees the social enterprise sector a fighting chance of winning a percentage of contracts, it is an attempt to push the boat along. It is a piece of a bigger jigsaw.

What I have to say through these two amendments builds on the practical points that I attempted to make in my Second Reading speech on 27 January on the Public Services (Social Value) Bill. It is good to see in his place the noble Lord, Lord Newby, who led on this Bill in your Lordships' House. These matters are all connected with the question of how in practice we add real social value to the processes of public sector procurement, and today we are particularly focusing on the health service.

I noticed in a recent newspaper article that Stephen Allott, who was appointed by Francis Maude in February to give smaller suppliers,

> "a strong voice at the top table",

told a journalist recently that work is well under way to create a fairer playing field for smaller businesses. Of course, many of these smaller businesses are social enterprises, because social enterprises are businesses. I welcome this but Mr Allott conceded that the slow pace of change meant that many companies were still unable to take advantage of the opportunities which Francis Maude promised them and continued to grapple with major hurdles, such as lengthy and burdensome pre-qualification

questionnaires or PQQs, high financial thresholds and high levels of liability insurance. Mr Allott said that he continued to hear about problems faced all over the country in both central government and the wider public sector. Mr Allott also rightly said that a cultural change among the 6,000 procurement professionals in central government was likely to be the biggest barrier to SME involvement. I agree.

On 20 November, Francis Maude also announced a plan for a commissioning academy. On 7 February it was announced that a £7 million leadership academy, run by Oxford University's Saïd Business School, would be set up with a focus on large-scale infrastructure procurement-for example, a new rail route to Birmingham and so on. We are told that the top 50 civil servants will attend. Oh dear! If the process for the procurement academy gets it so wrong, it shows the depth of the problem. The chosen focus is solely on high-profile mega-contracts and a handful of senior staff. While we clearly need to get these right as well, where is the focus on the 6,000 central government staff and, I believe, the 60,000 local authority and health authority procurement staff? This is where the focus is needed on this detail, because these are the people who spend large amounts of taxpayers' money, which has a profound implication for local communities across the country. Billions of pounds-worth of contracts are procured through them, and these are the people who in my experience keep getting it wrong at the front edge and often have a very limited understanding of what social enterprise is about.

More seriously, my colleagues and I are trying to do what we can to help the Government with these changes. Indeed, I am talking to the HR department of one central government department in Whitehall at the moment to try to second staff to take a view up the telescope and discover for themselves, for example, the unintended consequences of unreasonably high levels of liability insurance, and here I suspect that I must declare an interest. These two amendments are trying to encourage government to take a few further practical steps down this road. The Minister knows, as we all do, that there is still a long way to go.

The present procurement processes are broken and affect not just social enterprises. A pharmacist whom I know in an inner-city area has a highly innovative approach. He has been mentoring young people from a local school in the middle of a housing estate, some of whom have gone on to read pharmacy at university. However, he is finding that his approach and skills are not recognised by the local health service. The PCT recently ran a procurement exercise for a new pharmacy nearby. Clearly, it would have been to the benefit of the local community and local health services if this pharmacist had been able to extend his work, take over this new outlet and grow further linkages with social enterprises locally. Clearly the PCT cannot just give him the contract but you would have

thought that it might make sure that he knew about it by perhaps putting him in touch with someone who knew about PQQs, or ensuring appropriate weightings for added-value services and an in-depth knowledge of the local community. Not a bit of it. The PCT did not even tell the pharmacist about the PQQ process until 24 hours before the deadline. He thus did not even get shortlisted after the PQQ stage.

That says everything that is wrong with public sector procurement and why I have little confidence that any of the legislation, from the Localism Act to NHS reform, will achieve very much in practice if there is not a profound culture change in the way in which procurement teams think and operate. By the way, I could also if there was time, which there is not, illustrate the same problem from the major corporate's point of view. That very good company has taken the time and trouble to grow a partnership with the local social enterprise over many years. The company has understood the arguments as to why it makes good social and business sense to give greater weightings to the development of skills in local communities, only to find itself losing contracts because the procurement team in one major contract, despite all the talk in government, was simply ticking boxes and had no idea what the words meant in the real world on the ground or how meaningless the weightings were in practice.

I am sure that the civil servants who then gathered the numbers together in this contract felt that the procedures had been followed to the letter and every box was in fact ticked. In reality, something quite different happened. Perhaps some of us could offer some support to the NHS in running another procurement exercise, with the goal this time that when the PCT or its successor body commissions another pharmacy the staff get out of the office and discover the local context in which they operate and respond to it, and incidentally improve the quality of their working lives in the process by getting to know better some of the patients and professionals in the area.

I know from experience how well-meaning speeches can appear to press a green button in No. 10 or the Department of Health only to find that what happens in practice down in the machinery of government is something quite different. Unintended consequences are very real in this area of the machinery of government. We all know that healthcare markets are in their infancy. Philip Collins rightly said in the *Times* recently that they need to grow. It is time for many of the people writing to me to do what Mr Collins suggests and put aside sentimentality about the NHS and embrace patient choice, otherwise those who profess to be angels protecting the NHS will kill it. Social enterprise is up for this journey and wants to help and work with this and any successor Governments. Healthcare markets in England are in their infancy with regard to both supply and demand sides of the equation but both are underdeveloped. We need

competition but it needs to be a level playing field based not on theories or half-baked notions of fairness and equality but on real practice.

To tackle this we need more than grants to build capability in the social enterprise sector; we need fundamental change in the procurement culture of the NHS. It is about more than just creating guidelines. It is much more fundamental than that. These two amendments offer the Government a few further pieces of the jigsaw and seek to help Ministers create more social value from public service procurement. I beg to move.

Baroness Tyler of Enfield: My Lords, the hour is late but I wish briefly to explain why I have added my name to this amendment moved so compellingly by the noble Lord, Lord Mawson, whose credentials in this field are second to none.

In Committee it was argued that the Bill, as currently framed, could have serious unintended consequences both for social enterprises and for the wider voluntary and community sector. In my remarks, I want to focus on the wider voluntary and community sector. The basic concern expressed was that staff working on the NHS Commissioning Board, and indeed more widely, would interpret the Bill to mean that capacity building and other measures to support the development both of social enterprises and of voluntary and community organisations would be outlawed. A consequence of this would be to make it harder for charities and community groups, which are often very small with tiny management capacity, to provide the services and support that many people, particularly the most vulnerable and the hard-to-reach, rely on.

I know that many charities and community groups are particularly effective in reaching out to the people who the statutory sector finds hard to reach and they then can advocate on their behalf and indeed can help provide an authentic user voice in the system. In Committee the Minister gave assurances that essentially these concerns were unfounded and that the Government will,

> "ensure that procurement practices do not unfairly restrict the opportunities for charities, voluntary organisations and social enterprises to offer health and care services".-[*Official Report*, 28/11/11; col. 108.]

When I followed this up afterwards with very helpful officials at the Department of Health they said that the NHS Commissioning Board would be publishing guidance on this issue for commissioners. That guidance I am sure will be helpful but is it enough? There is always a danger that guidance will not be adhered to, will be misinterpreted or indeed will not be seen.

I want to refer very briefly to my own experience in this field. Until a month ago I was chief executive of the charity Relate. Our local centres which are very small with very limited management capacity found themselves in a commissioning exercise in relation to the talking therapies part of the NHS services. It was not an encouraging experience, to be frank. These local centres often found that potential NHS commissioners would wrongly assume or argue that the local Relate centres would be quite unable to mesh with the NHS's systems, data, outcomes measurement or requirements. Often this simply was not the case but it reflected a lack of understanding on the part of the commissioners. I know that this has been the experience of a number of other charities both big and small.

In conclusion, this modest amendment would be more effective than simply guidance in preventing these unintended consequences. I very much look forward to hearing the Minister's concluding remarks.

Lord Newby: My Lords, it is with very considerable diffidence that I rise to speak at this hour and for the first time on this Bill. Tomorrow we have, I hope, the Third Reading of the Public Services (Social Value) Bill which I introduced at Second Reading in your Lordships' House. That Bill will require all public bodies, including health service bodies, to consider the broader social value of tenders when deciding on who to place the tenders with. At one level, therefore, it could be argued that these amendments might not be necessary. What concerns me is what happens after, as I hope will be the case, this Bill passes tomorrow. What change will take place in the health service and elsewhere? One of the absolutely key changes that has to take place is the one set out in Amendment 64B; namely, that weightings must be attached to social value at the point at which companies, social enterprises, charities and so on are submitting their tenders. Unless the procurement regulations are changed to provide for such weightings it will be very difficult to have the kind of change in culture and practice which the Public Services (Social Value) Bill seeks to achieve.

I wonder whether the noble Earl, who has already very helpfully in a debate on a previous amendment committed the Government to giving guidance in respect of one matter, will be prepared to commit the Government now to the extent that the Department of Health would require NHS bodies commissioning services covered by the Public Services (Social Value) Bill to include within the tender document a weighting in respect of social value.

The Earl of Sandwich: My Lords, having worked in the voluntary sector for many years, I could not resist saying one word in support of my noble friend. The only word that I missed from his speech and that of the noble Baroness, Lady Tyler, was "innovative". The

voluntary sector is ahead of the National Health Service in so many ways, as are other sectors.

We are coming to an amendment, if not tonight then probably on Wednesday, regarding addiction to prescribed drugs. This is a field where we have practitioners who are the people who do it; they are not the bureaucrats behind. It is an area where the Bill needs strengthening. The noble Lord, Lord Rooker, and I tabled a very important amendment on this matter last time around. I can hear him saying, "Let us take every opportunity to strengthen the Bill when it comes to the voluntary sector and bureaucracy".

Lord Beecham: My Lords, I warmly congratulate the noble Lord, Lord Mawson, not only on the substance of his amendments but on his sense of timing, because we are now very familiar with complaints from the voluntary and community sector in relation to the welfare-to-work programme. It was anticipated that the sector would be heavily involved in helping to place people into work, but, in practice, we have seen most of that endeavour carried out by much larger companies, with the sector playing a very limited role. It is precisely to avoid that outcome that the noble Lord has tabled his amendments. In particular, I am attracted to and wholly support subsection (2) of the new section proposed by Amendment 64A, which would confer on the board the capacity to,

> "take specific action to support the development, including capacity building, of the voluntary sector, social enterprises, co-operatives and mutuals".

That seems to me the kernel of the two amendments, which we very much endorse. In a mixed economy of provision, that sector needs to be developed and supported.

A further potential opportunity is raised by new Section 13W, on page 23 of the Bill, which confers on the board a power to, "make payments by way of grant or loan to a voluntary organisation which provides or arranges for the provision of services which are similar to the services in respect of which the Board has functions". That may be implicit in subsection (2) of the amendment, although new Section 13W appears to limit that power to grant or loan to a voluntary organisation, which would not necessarily include the social enterprises, co-operatives and mutuals referred to in the noble Lord's amendment. Perhaps the Minister, if he is sympathetic to the amendment, will look at whether the provision about grants and loans in new Section 13W might be expanded.

It is never too late for a little pedantry. I want to raise with the noble Lord, Lord Mawson, a couple of questions about the wording of parts of his amendments. Proposed subsection (1) of the new section proposed by Amendment 64A refers to the board exercising its functions,

> "so far as it is consistent with the interests of the health service".

I think that he means the interests of patients, rather than the service as such, which I would have thought more consistent with the general approach.

There is also a potential problem with subsection (3), which seeks, understandably, to provide that the board should take such steps as might produce,

> "a level playing field between providers ... meaning that one sector of provision is not more disadvantaged than another and relative benefits can be taken into account".

That seems potentially to conflict with Clause 146 of the Bill, which would appear to rule out such a deliberate adjustment in favour of the sector. That is one good reason why my noble friend Lady Thornton will move an amendment to delete that clause and I hope that the noble Lord will support it.

A further question relates to a matter touched on by the noble Lord, Lord Newby, and relates to the second amendment, which, I confess, I do not quite understand. The amendment provides that the board may promote the inclusion of weightings in the procurement process,

> "which reflect wider social, economic and health outcomes for each local health area".

Does that relate to the conditions that exist at the time of the procurement rather than outcomes-I do not see how outcomes would fit-and I am not clear what are the weightings? They cannot be only financial weightings. Is it to be a consideration to encourage the letting of contracts to the voluntary and social enterprise sector because of the particular nature of the locality? It is not clear and perhaps when the noble Lord replies he will-at least for my benefit- touch on that.

Interestingly, the two amendments relate to the part of the Bill dealing with the functions of the National Commissioning Board but purely to the health service provision, whereas proposed new Section 13M on page 19 refers to both health and social care provisions. I can understand why the amendment is limited in the way that it is, but I assume-again perhaps the noble Lord will confirm this-that he would envisage

ultimately the same principle being applied to the provision of social care services. Is it not an illustration of the failure to develop the social care part of the Bill, which we touched on earlier?

Having said that, I strongly support the thrust of the noble Lord's amendment and repeat my congratulations to him.

Earl Howe: My Lords, my noble friend Lady Tyler was quite right because the noble Lord, Lord Mawson, has spoken compellingly, as he always does, and I, for one, am grateful to him for the insights that he gave us.

I begin with an observation which I hope is incontrovertible: voluntary organisations, staff mutuals, co-operatives and social enterprises all play vital roles in delivering innovative, high-quality, user-focused services within their local communities. The Government firmly believe that such organisations have a strong role to play in the health and social care system. This is due to the experience, expertise and insights that they can offer to commissioners and the system more widely.

As I hope your Lordships will recognise, the Bill shows the Government's commitment to fair competition that delivers better outcomes and greater choice for patients and better value for the taxpayer. We want to see providers from all sectors delivering high-quality, person-centred health and care services: we do not want to favour one type of provider over another.

The Government are also supportive of everything that the noble Lord said about the importance of social value and the key role that social enterprises and other organisations can have in building and promoting it. On my visit a few months ago to the Bromley by Bow Centre with the noble Lord I was able to see first hand the excellent work that Andrew Mawson Partnerships has done in reviving and stimulating the local community. One cannot fail to be impressed by this model and vision, which we know works and want to see more of.

Having said that, we need to pause and reflect because these amendments are unnecessary. Amendment 64A is not appropriate because it cuts directly across the role of the NHS Commissioning Board. Simply put, the role of the board is to be a commissioner, not to build providers. We are clear that no provider, whether due to its size or organisational form, should be given preferential treatment in the new system. The provisions introduced by Clause 22 prevent the board, and the Secretary of State and Monitor likewise, giving preferential treatment to any particular type of provider, be they public, for profit or not for profit.

I know that this has generated some concern among voluntary and community organisations. I would like to assure noble Lords and the sector that the board will still be able to make grants and loans to voluntary sector organisations. It will not be able to do that for the sole purpose of increasing the proportion of services provided by the voluntary sector. The board could, however, invest in voluntary organisations where they bring the credible voice of patients, service users and carers to inform commissioning and the development of care pathways, or where the sector's expertise could contribute to the commissioning support required by CCGs and the board. Those are just some examples. The power-which we included in the Bill through an amendment in Committee in another place-mirrors the power that the Secretary of State has now under Section 64 of the Health Services and Public Health Act 1968, which is exercised by strategic health authorities and PCTs. Equivalent provision is also provided in the Bill for CCGs in Clause 25, inserted as new Section 14Z4 of the National Health Act 2006. Voluntary organisations should therefore have no reason to fear that they will be unduly affected by the new system. However, as drafted, Amendment 64A would disadvantage NHS trusts and foundation trusts for profit providers. As a result, I cannot accept it.

Lord Beecham: I thank the Minister for giving way. Could he clarify the situation? Does the voluntary sector, as he has described it, relate also to social enterprises, co-operatives and mutuals; or are they regarded as being in a different category and therefore not eligible to receive grants and loans under the provisions of the Bill as it now stands?

Earl Howe: My Lords, as regards grants and loans, we are clear that voluntary sector organisations and social enterprises-and I include bodies of that kind in the same grouping-are and will still be eligible for grants. The key is that those grants must not be given solely because they are voluntary sector organisations or social enterprises. It is a nice distinction, but really it means that voluntary sector organisations and social enterprises will still have to compete fairly for a contract on a fair playing field with other providers. As I have indicated, that means that NHS providers and others are not disadvantaged in the market for NHS-funded services. Nevertheless, the scope will still be there, and they are indeed classed as voluntary sector.

I am also grateful to the noble Lord for raising the important issue of social value. I can assure him that the Government are sympathetic to these principles. That is why the NHS procurement guide already enables NHS commissioners to take account of social and environmental outcomes in their procurement. The Department of Health has also, through its social enterprise fund, invested more than £80 million in the health and social care sector. To answer my noble friend Lord Newby, I am also fully aware of the support for these principles in the Public Services (Social Value) Bill currently being

considered by noble Lords. Put simply, if that Bill receives Royal Assent, Amendment 64B will not be necessary. The Public Services (Social Value) Bill will make NHS organisations have regard to economic, social and environmental well-being in procurement, and the Government welcome that. The NHS procurement guide, as I said, already enables NHS commissioners to take into account other outcomes in procurement, and we will continue to encourage them to do that, so I think, in the NHS at least, commissioners will notice little change in the guidance that is given to them. Make no mistake, we see a valuable role in the future healthcare system for voluntary sector organisations, social enterprises, staff mutuals and co-operatives. However, that cannot be at the expense of other types of provider, including particularly NHS providers. I hope very much that your Lordships will agree that these two amendments are therefore unnecessary.

Lord Mawson: My Lords, I am most grateful to the Minister for what he has had to say. I am trying not to be difficult but to be practical. The future of the health service depends on practical details being got right in the machinery of the NHS, which is where I seek to draw the Minister's attention. For me it is not about words about whether it is the health service, or patients, or words in an amendment; it is about what is actually going on in the machinery. I fear that the practice is still too little understood and that there is more work to be done here. I know that this is the beginnings of a journey and that we have further to go with the various elements of the jigsaw.

The purpose of the amendments was really to draw the attention of the Minister and the Government to this and to encourage them to focus on the detail, and to encourage colleagues within the NHS to spend a bit of time with practical entrepreneurs who have to try to make this work. We want them to examine in a few details some real pieces of work where people have attempted through weightings and other mechanisms a level playing field-because people like me do not want special favours, but we do want a level playing field. All that I can say is that in practice it is not level. If the Government want many of their aspirations for a broader involvement in the health service with social enterprise and others in the voluntary sector, unless those practical details are better understood and addressed, I fear something quite different will happen.

Having said that, I thank all those who have taken part in this debate and who helped me with the amendments-particularly the noble Lord, Lord Rooker, who is not in his place, but who has been very helpful. The noble Baroness, Lady Tyler, has also been very helpful. This is not a party-political debate; it is a practical matter that seeks to help to move the NHS on into new, more patient-focused reality. The amendments are simply an attempt to flag up yet again the issues. I beg leave to withdraw the amendment.

Amendment 64A withdrawn.

Amendments 64B to 66 not moved.

Amendment 66AA, in substitution for Amendment 66A, not moved.

Amendment 67 had been withdrawn from the Marshalled List.

Amendment 67A not moved.

Amendment 67AA, in substitution for Amendment 67A, not moved.

Amendment 68

Moved by ***Earl Howe***

68: Clause 22, page 22, line 16, after "13E" insert ", 13G"

Amendment 68 agreed.

Amendment 69 had been withdrawn from the Marshalled List.

Amendment 70 not moved.

Consideration on Report adjourned.

House adjourned at 11.34 pm.