4.31 pm

Amendment 99

Moved by ***Lord Patel***

99: Clause 20, page 16, leave out lines 27 and 28 and insert-

"(b) HealthWatch England, and"

Lord Patel:
My Lords, I apologise to the Minister and to the noble Baroness, Lady Northover. Yesterday afternoon I told them that I was degrouping these amendments to be taken at a later stage of the Committee.

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That was, however, before I got beaten up later in the day and lost my normal aggression. I had to retable them and I apologise for that. I hope that it is possible to take them today.

I will concentrate mainly on HealthWatch England. The purpose of this amendment is simple-to make both HealthWatch England and local HealthWatch organisations independent bodies and, in doing so, to give patients and public a truly independent voice. It does not change the broad thrust of the policy in any way, nor does it have any more resource implications.

In the Government's list of intentions for HealthWatch England, the Minister recognised the need for it to maintain independence; to set its own work programme; to publish its own annual report to Parliament; and to have independent membership. He also said that regulation would be brought forward by the Secretary of State in relation to this. It would also provide advice directly to the Secretary of State, the NHS Commissioning Board, Monitor and local authorities. At the same time, the list also suggests that HealthWatch England will be able to advise the Care Quality Commission on the views of people who use the service; that it will be a committee of the CQC; and that the CQC will respond in writing to HealthWatch England's advice.

HealthWatch England's operating plan, which was discussed by the CQC board, suggests that its main focus will be local; it will be small and strategic; its accounting officer will be the CEO of the CQC; its staff will be employed by the CQC; and service-level agreement on its functions will be put in place. The plan

also suggests that HealthWatch England's committee will be appointed by the CQC; that its chair will be subject to CQC board governance; and that conflicts of interest will be decided by the board. HealthWatch England will publish reports on a "no surprise" basis. This is quite contrary to the suggestion that HealthWatch England should be independent of the CQC. The CQC clearly sees itself having a close relationship with HealthWatch England, with the latter relying on it for significant analytical intelligence and other analytics and data. Joint data collection will not be appropriate for the diverse functions of the two organisations. The relationship between the two has not had a good start either, with LINks and others feeling that they have not been fully consulted by the CQC in developing the plan.

The proposed duties of HealthWatch England are intended to provide local HealthWatch organisations with advice and assistance in relation to promoting and supporting the involvement of people in the commissioning, provision and scrutiny of local care services. Under the duties, people will be able to monitor local health and social care services; their views will be obtained on the standard of local services; and information will be gathered on local need for and experiences of care services. Recommendations will be made to commissioners and providers of services about how local care services could or should be improved.

The relationship between HealthWatch England and local HealthWatch organisations is important. The Bill establishes HealthWatch England as a statutory committee. Ministers say that the relationship between HealthWatch England and local HealthWatch organisations must be an open dialogue so that critical knowledge of

the views and experiences of patients and local service users will have a real influence on the delivery of health and social care. The aspiration is that local HealthWatch organisations and HealthWatch England will collaborate with local authorities and clinical commissioning groups. However, the Bill does not give local HealthWatch organisations any specific role in relation to clinical commissioning groups. They have no direct role in influencing the commissioning arrangements of CCGs in relation to the needs of local people, nor do they have any say in it.

In my view, therefore, HealthWatch England should be established as an independent body outside the CQC; be the guarantor of an independent local

community voice; have clear accountability to local HealthWatch organisations; and have adequate resourcing-there are concerns that the CQC will not adequately fund HealthWatch England. It should provide an expert team that has the knowledge and experience to build HealthWatch; and support the transition of LINks into HealthWatch organisations and the development of local HealthWatch's ability to carry out its five statutory functions. It should provide local HealthWatch organisations with support, training, advice, resources and expertise on health and social care policy, legal processes and myriad other issues if local HealthWatch is to take off quickly. On the basis of current and previous experiences, I feel that the CQC's belief that local HealthWatch can be built and become operational quickly is misplaced-that is the experience of LINks, too.

HealthWatch England should have a capacity to carry out research that is needed by local HealthWatch organisations to support their work. HealthWatch England should support the development of local expertise to gather information and data from all sources-public, patients, complaints and serious incident investigations-so that it has a well developed and informed view of the state of local health and social care services. It should support the development of regional HealthWatch organisations so that a powerful regional voice on services and commissioning can be developed. It should provide the capacity to elevate local and regional demands for better health and social care to the NHS Commissioning Board, the Secretary of State, Monitor and the CQC. It should support the co-ordination of major demands for changes to health and social care policy and commissioning, integrating local HealthWatch.

It was pointed out to the CQC that a research capability was essential for HealthWatch to function. If a potential service problem is suspected, it is necessary to check how widespread it is. Beyond this, the organisation must be able to carry out original research on consumer needs in order to improve services. No research capability had been placed in the plan that the CQC develops. It appeared in meetings with LINks that the CQC might commission research, but we know from examples that research at a local level is important-staff being the classic example.

Diverse and inclusive HealthWatch organisations could substantially increase the power and influence of local people to monitor services more effectively, improve safety, influence commissioning and provide a voice that will be heard in the local, regional and

national development of health and care policies. To be effective, HealthWatch, nationally and locally, must be fully independent and democratic. Others with experience have informed me that the dependent relationship that HealthWatch is intended to have in relation to local authority is deeply flawed. They believe the proposed system will be expensive and difficult to establish. The decision not to ring-fence funding will make these bodies weak and vulnerable.

The way forward is for HealthWatch England to be an independent body helping the local HealthWatch organisations, which should also be independent of local authority. If the Government are serious about what they say-that the Bill is about putting patients and the public at the centre and the slogan,

"no decision about me without me",

is what they wish to follow-then the way to create public confidence is to have HealthWatch England as an independent body. I beg to move.

Baroness Wheeler:

My Lords, I start by saying that I was not one of the ones who beat up the noble Lord, Lord Patel, over grouping issues, although it was extremely frustrating to have them appear and disappear all the time. Anyway, we now have our list and I am speaking to that.

I am pleased to support the amendments in the group, which have two important aims. First, to ensure that HealthWatch England and local HealthWatch organisations are truly involved and consulted where decisions are made about the development and planning of commissioning services and on reconfiguration or changes to services. Secondly, to ensure that it is an independent statutory body and not a subcommittee of the Care Quality Commission.

The Government's far-reaching proposed changes to the NHS, with the emphasis on competition and regulation, make the need for HealthWatch England to be given robust and independent scrutiny powers even more important. Amendment 305 from my noble friend Lord Harris and myself is a probing amendment with the intention of ensuring that HealthWatch England and local HealthWatch organisations have the strengthened power and functions they need. It establishes HealthWatch England as an independent body responsible for providing the Secretary of State, the NHS Commissioning Board, the Care Quality Commission, Monitor and local authorities with information and advice on the views, needs and experiences of users of health and social services, and the views

of local HealthWatch organisations on care standards and how they can be improved.

Under Amendment 305, HealthWatch England is responsible for providing local HealthWatch organisations with resources, advice and assistance. The amendments of my noble friend Lord Whitty, Amendments 318C and 318D, set out similar and additional powers and functions for HealthWatch England to those proposed in Amendment 305. We fully support these, which include powers of investigation into complaints and powers to seek disclosure of information from health and social care providers, the NHS Commissioning Board, CQC and others. Important functions also include information, research and representation functions.

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The independence of HealthWatch England from the Care Quality Commission is vital if it is to be the national service users' watchdog and champion. It must be able to hold regulators in the whole of the health and social care system to account and be the independent guarantor of the rights, duties and independence of local HealthWatch organisations. Given the uncertainties still surrounding how Monitor and the CQC will work together, and the current trials and tribulations facing the CQC, how realistic is it to expect the CQC to undertake this role or for HealthWatch England to function properly as a CQC committee?

Does the Minister acknowledge these problems? Will he-or she-consider working with NALM and other interested stakeholders to produce an alternative model for HealthWatch England that will secure the Government's stated policy for a powerful and independent system of public involvement in health and social care? To be effective, local HealthWatch must be able to scrutinise how consortia and health and well-being boards undertake public engagement and transparency and are ensuing that the public voice is embedded in the care pathway design. They should also be given the right to comment on tenders and commissioning contracts before release.

LINks organisations currently have significant powers to enter and view the premises of all health and social care providers regulated by the CQC-another potential conflict of interest if the CQC relationship is not changed. These powers are often little used by local LINks organisations and we hope that their retention in the Bill and robust guidance to local HealthWatch organisations on how they can be applied to the benefit of improved patient care and treatment will lead to these important powers being more frequently used. I would welcome the Minister's endorsement of that.

4.45 pm

On the question of the transition from LINks to HealthWatch, we would underline that the involvement of LINks organisations is essential to ensure that the skills, knowledge and dedication of the existing volunteers are not lost. I also emphasise the importance of ensuring that HealthWatch local organisations are properly funded. This is an uncertain time for the development of local HealthWatch, with local authorities beginning to tender for hosting HealthWatch organisations. Moreover, in Surrey, Sutton LINk, for example, has been selected as a pathfinder HealthWatch but is rightly concerned at how realistic it is to take on a new role and the increased costs of undertaking new duties such as the complaints advocacy without any form of transition or improved funding. Will the Government reconsider their decision not to fund pathfinder LINks HealthWatch organisations to enable an effective transition to HealthWatch?

We should recognise the widespread concern raised by current LINks organisations that the HealthWatch arrangements make them dependent on the local authority for funding. With local authorities' greater involvement in healthcare, particularly for public health, how will HealthWatch organisations be able to

exercise independence and have public confidence and trust in their role? I look forward to the Minister's response on these key transition issues.

Lord Harris of Haringey:

My Lords, I apologise to my noble friend Lord Patel if he in any sense felt beaten up by me. I absolve my noble friend Lady Wheeler from any involvement in that process. I also apologise to the long-suffering officials in the Government Whips Office. If my robust style is mistaken, they should really see what I am like when I am angry.

I added my name to a number of amendments in the various versions of this group. I also proposed Amendment 305. If the noble Baroness whom I believe is replying to this debate is planning to highlight any technical flaws in that amendment, I should point out that I drafted it myself. Therefore, it no doubt does contain a number of technical flaws. But the purpose of the amendment is to assess the feeling within the House and the strength of feeling in the department about the extent to which it is important that HealthWatch England and HealthWatch organisations at local level should be independent.

The principle underlying this group of amendments is straightforward-the centrality of the voices of patients and users in the NHS. That voice must be, and must be seen to be, independent of the various provider and regulatory interests. That is what underpins all of the different amendments.

I find it difficult to understand how the Government will oppose the amendments. They keep telling us that the voice of the patient and the user will be central to all these arrangements. They say that that is their intention. But they must be aware, because everybody else is, of the cynicism and doubt that is being expressed around the country about this whole package of NHS changes. Therefore, they should be able to reassure patients and users that their voices will be heard at every level within this complicated restructuring that will take place. That is extremely important.

What is more, it will be important for that voice to be seen to be independent. Members of the public will be concerned about what is happening. They will worry whether their doctors, who that they do not fully understand as being part of commissioning groups, will somehow be making judgments about their care, influenced by financial interests. They will want to be assured that they can go somewhere for proper advice and support, and that that place will genuinely be independent of all of those interests.

A huge expectation is now being placed on local HealthWatch organisations. They are expected to provide that independent advice and information, to be able to monitor the nature of the service at local level and to be able to comment on the various changes that are taking place and on the proposals that are coming from the plethora of commissioning groups, senates and goodness knows what else we are going to have. They are going to be there to make recommendations. So, there will be enormous expectations on behalf of the public as to what these groups are going to do. Similarly, the national body, HealthWatch England, will have enormous expectations upon it. That is why it is so important to get these arrangements right. The

proposals for HealthWatch England and local HealthWatch are an advance on what we have at present in terms of LINks. There is no question about that-they are a step forward. The record of successive Ministers and Governments in terms of patient representation in the NHS is not very good. This is a step forward from where we are at the moment. So, let us try to get it right. Why not deal with what are comparatively small issues in terms of how the system works?

The trouble is that, at the moment, the arrangements that the Government are proposing are flawed in two key respects: first, on the issue of independence, as the noble Lord, Lord Patel, has already indicated; and secondly, in terms of the resources available. Let us consider for a moment the position of HealthWatch England as a sub-committee of the Care Quality Commission. That might be a very neat way of not increasing the number of quangos by one; it may be that was the sole motivating feature. However, the reality is that it dangerously compromises the independence that I talked about as being so important. Often, HealthWatch England will have to say, on behalf of local HealthWatch organisations, that the regulator should be doing something, has failed to do something or has been inadequate in the way that it has done that. In the last few weeks, we have seen the Minister's colleagues in the Department of Health making quite critical comments about the way in which the CQC has fulfilled its remit. If Ministers are saying that-and Ministers are, after all, the paymasters of the CQC-what is it going to be like for those people whose remit is to raise these issues but are themselves subordinate to that regulatory body? It is going to be a real conflict and a very difficult position for them. The nature of that relationship-the fact that they are a mere sub-committee and are subjected to all of the panoply of arrangements that go with that-is going to be seriously limiting.

I am aware that the CQC is making enormous efforts to try and demonstrate their good faith in all of this. I am sure that the individuals involved have good faith as far as this is concerned. However, we are here considering legislation that will set those arrangements. Once those arrangements are set, the good will of the individuals who may be trying to make it work at the moment may not persist-not because those individuals will change their minds, but because, over time, those individuals will move on and others will take their place. Budgetary and other pressures on the CQC will rise. The feeling that they do not like being criticised by a body that is technically subordinate to them will increase. That is why that arrangement does not work.

There is an even stronger argument as to why local HealthWatch organisations should not be subordinate to principal local authorities in their area. The Government's flaws here are flaws twice over. Not only are they imperilling the independence of local HealthWatch organisations by saying that-even though they are supposed to be independent-they are creatures of the local authority, the funds will be provided by the local authority and many of the facilities may well be provided by local authority but, because the funds will not be ring-fenced, it will be far too easy for local authorities to start to apply the screws if they do not like the criticisms that come from it.

A major conflict of interest is being created. HealthWatch cannot be accountable to, and at the same time funded by, local authorities because the bodies which commission and provide the services are the local authorities in many instances. However, the Government are saying that HealthWatch can advise members of the public about those services. How can HealthWatch organisations be funded by the same bodies that are commissioning and providing those services? This is precisely the area where the confidence of members of the public and of individual patients is so important. They have to go for advice to a body which is funded by the people about whom they wish to take advice. That hardly looks independent or satisfactory. If HealthWatch is made accountable to local authorities as the Bill proposes, the public will, frankly, have no confidence in that and all the efforts that the Department of Health and the Government have made to try to create a better structure will be wasted. That resource will be wasted because the public will not have confidence in these arrangements.

There is also a failure to protect the funding. I do not know how many hot coals Ministers in the Department of Health had to crawl over to get £60 million out of the Treasury for HealthWatch. I am not suggesting that the Department for Communities and Local Government is any more evil than any other government department, but if you hand the funding to that department, which then hands it on to individual local authorities without a label saying, "Not only is this money to be used for HealthWatch but it cannot be used for anything else", my experience as a former council leader tells me that you cannot guarantee that the money will be used for the purpose that you wish.

I spoke earlier about localism and said how wonderful it was that the Government should devolve responsibility for this issue. However, it is not a wonderful example of localism if you expect something to happen, you pass the money on and then you are shocked if the money is not used for that purpose. If you want the money to be used for a particular purpose, you have to label it and ring-fence it. However, the Government will not do that. They say that they cannot do that as it would be inappropriate in the spirit of localism.

I have received numerous e-mails and messages from LINks on this very subject. Their experience of not having ring-fenced budgets this year is salutary. One message states:

"As a LINk our funding was reduced by the local authority by 65 per cent this year".

Another states:

"I have spent 30 years as a senior business professional and business consultant and it is ludicrous to set an organisation targets to be funded by set criteria and then reduce those funds by 65 per cent. This makes a mockery of the organisation's ability to carry out its public remit".

That is what is happening at the moment. What guarantees can the Government give that it will not happen in the future?

There is a technical point here. The Department of Health has presumably secured these funds through the comprehensive spending review. Who will own those funds the next time that the comprehensive spending review is negotiated? Will it be the Department

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of Health or the Department for Communities and Local Government? If it is the Department for Communities and Local Government, how will it rank given its other priorities which have nothing to do with HealthWatch? If it is the Department of Health, how will it answer the question from the Treasury, "How do you know that this money is being spent in the way that you intend?". It will not be able to answer that question, as I suspect that the correct answer is that the money will disappear. LINks already have huge concerns about the resources question.

The other element of this concerns what sort of patient representative mechanism we want. Do we want something which is top-down or something which comes from local organisations? The amendment that stands in my name seeks to establish an arrangement whereby local HealthWatch organisations have ownership of the national body which speaks in their name. I believe that that is essential. Even if you created HealthWatch England as an independent structure without the problems of it being a tool of the regulator, you will still not get the necessary buy-in at local level unless local organisations feel that they are part of it and have a say in its organisation. I speak as someone who was director of the Association of Community Health Councils for England and Wales for 12 years, and I know how important it was for the member organisations to feel that what we were saying as the national body reflected-not to the letter, but reflected-what they felt was important as local organisations. If you do not have that mechanism, if you do not have that process built into the legislation, I am afraid that you will create a gulf between the national body and the local bodies. That is surely unsatisfactory.

The Government's proposals could make an enormous difference to patient representation in the new NHS, and patient representation is going to be enormously important in the new structure, because I think that many patients will feel disempowered and worried by what is happening. However, those arrangements are flawed unless the Government accept the spirit of the amendments in this group-and unless they accept that HealthWatch, both nationally and locally, should be independent, and that resources should be clearly ring-fenced and clearly identified and cannot be used by bodies that have no interest, necessarily, in patient representation used for other purposes.

5 pm

Lord Warner:
My Lords, I have added my name to Amendment 99 and to a number of other amendments tabled by the noble Lord, Lord Patel, and my noble friend Lord Harris. I do not want to speak for very long on this issue. I have some inhibition about speaking about this because I do not think that my own party's record on patient representation was extremely startling. I had to take some of those measures through your Lordships' House and usually did not get the better of the arguments with the noble Earl on these issues. I accept that the Government have started off pretty well on this issue and that they have a good brand-HealthWatch is quite a good brand. I am an athletics fan, however, and the Government are beginning to look like a 200-metre runner who has moved up to 400 metres but is now starting to run out of steam on

this issue in the last 100 metres. What I think has happened is that the money has started to dominate the discussion.

I also recognise here a favourite Department of Health word-hosting. There are two phrases that used to worry me as a Health Minister: "the NHS family", which was usually an excuse for doing something foolish; and "hosting". The danger of hosting is that, for what seemed to be perfectly good reasons, you put one organisation in the maw of another organisation whose culture is fundamentally different from the needs of the organisation being hosted. The real danger here is that there is no obvious similarity between a regulator and a patient representative organisation.

I will give the noble Earl just one example where the Government would do well to pause and think. If you are the parent of someone with a learning disability who is in a home which has mistreated and abused them and the regulator has

let you down, or you perceive that the regulator has let you down, you are not going to be very pleased to find that the regulator is the very same body that is hosting the national body representing patients. That is a real example, not a phoney example. I think that there could be many such cases-and we will have a debate on Dilnot and social care on Thursday. However, there are some serious problems in the funding and quality of some of our social care institutions. The regulator is going to have a tough time in these areas over the coming years. It is a mistake for HealthWatch England to be hosted, in effect, by the regulator. Given the size of the NHS budget, the Government are spoiling their ship for a ha'porth of tar, to use a corny phrase, by not finding the money to fund this body adequately, so that it can stand on its own two feet and be secure and independent, and so that it can be allowed to be seen to be secure and independent by the patients who will put their trust in it.

I shall end on the point made by the noble Lord, Lord Harris, about ring-fencing. I can give the noble Earl a good example of where the Government have tried to do the right thing. They tried to put some extra money into social care that would go down to local authorities to improve the volume and quality of social care, but they did not ring-fence it. It was the best part of £1 billion, out of the £2 billion increase in social care funding. We now have a lot of people who thought that that was a jolly good idea. However, as it was not ring-fenced, the Government will not get any credit for it. It has gone into local budgets, but we do not know where. If you talk to any director of adult social services they will tell you that one of the problems was that the money was not ring-fenced, so they cannot reassure the Government that the money has gone to the purposes for which the Government sent it down the conduit to the local authorities. There is a very real danger that the same will happen with the HealthWatch money that will go down to the local level. I strongly support these amendments.

Baroness Masham of Ilton:
My Lords, I spoke on this subject at Second Reading, and I want to go back in history for a few minutes. I remember that when the community health councils were closed down, the noble Earl, Lord Howe, and I felt strongly that the

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health forums which were put in their place should be independent. If a local HealthWatch organisation is linked too closely to its local authority, it will be difficult for it to be able to speak out if it finds that both health and social care facilities are not up to scratch. What happens if they disagree with the CQC? Patients often need help, so an independent body would be much better to help

them with their problems. It is vital that HealthWatch is adequately funded to do a useful job, otherwise it will fail. Perhaps I may give an example concerning a rural area. What happens if there are not adequate funds for the payment of members' travel expenses? That has been found with the local LINks. I hope that the Minister will give this serious consideration.

Baroness Cumberlege:

My Lords, I have listened to the debate, and some powerful arguments have been put forward for an independent HealthWatch England. However, I am not sure that that is the right answer. The noble Lord, Lord Harris, said that he feels that the Bill is setting up the new arrangements, and of course he is right. However, when one is setting up new arrangements, it is a good idea to look at what has happened in the past. Looking back to the confederation of CHCs, one sees that it never actually made an impact. I think that that was probably because the initiative for setting up that body came from the CHCs themselves, and so the confederation had no formal legitimacy, no clout and few resources.

Lord Harris of Haringey:

I would not disagree with the point about the resources, but the initiative to set up the association-not a confederation-came from the noble Lord, Lord Owen, who was Minister of Health. He announced, in what he assumed would be a very positive fashion, that he wanted to see a national Association of Community Health Councils. However, as he had not spoken to community health councils first, they felt considerable dismay about the setting-up of a national association at the behest of a Minister. The resolution to support the creation of the association was carried-I cannot remember the precise figures-by something like only 107 to 93. I am afraid that the noble Baroness's argument is flawed.

Baroness Cumberlege:

My Lords, I am very grateful to the noble Lord, Lord Harris, for his history lesson. Perhaps I should not go on to the Commission for Patient and Public Involvement in Health. Perhaps he remembers that organisation, which never quite worked. I think that it did its best, but it failed to influence the Labour Government of the time. Perhaps it was a bit too strident. Maybe it was not canny enough. Maybe it did not build the relationships that are so critical when one is negotiating a change, especially with a big beast like a Government. Of course, the Labour Government closed that one down very hurriedly.

The proposal in the Bill is that HealthWatch England should be a committee of the CQC, as has already been said. There are advantages in that, provided that

there are some safeguards in the way that it works. My three amendments seek to achieve those safeguards.

There are advantages in being at the top table, knowing what is going on, and building the necessary relationships to influence policy and practice. The

CQC will, of course, have the resources to collect and analyse data on a national scale. Provided that it shares that data generously-and it must do so-it will enable HealthWatch England not to have to build its own infrastructure in order to operate effectively. That will also enable HealthWatch England to have a strategic role in shaping the new NHS. It is very important that it should not just be a sounding board for local issues, but should have a strategic vision as well. The CQC will of course learn of the issues that need addressing through the real experiences of patients, through HealthWatch England, which will be at the table.

We have to understand what both organisations bring to the party. The CQC is the regulator. Its duty is governed by the statutory standards for healthcare and it has the indicators to measure them, as set out in the Health and Social Care Act 2008. HealthWatch England brings something different: the priorities, the experiences and the views of patients and the public, through local HealthWatch organisations. Played right, this combination could be very powerful. It could deliver the accountability that reflects both the priorities of government, derived from the democratic process, which I think of as the theory, and the actual experience of those who depend on health and social services during what may be the most vulnerable time in their lives, which is the reality.

If this combined perspective, to be embedded in regulation, is to work well, it is essential that HealthWatch cannot be dictated to or steered by the CQC. It must speak with a clear, strong, independent voice. This requires two things: first, the appropriate balance of membership within HealthWatch England; and, secondly, the appropriate status for its advice within the functions of the CQC. The status of HealthWatch England as a committee of the CQC may be quite pleasing in its value for money and its legislative simplicity, but it does not guarantee that clear, strong and independent voice. This is the voice of the victims who have been so badly let down by the NHS. It is the voice that has been chronicled so meticulously in the first Francis report on the mid-Staffordshire scandal, the Bristol inquiry, and other reports.

Therefore, my first amendment, Amendment 307A, ensures that the majority of the members of HealthWatch England are not also members of the CQC. This

avoids the advice of HealthWatch England being biased through corporate responsibility with the CQC. My second amendment, Amendment 308A, ensures that the majority of the membership of HealthWatch England is elected from the members of local HealthWatch organisations. This permits the introduction through regulation of provisions to ensure that elections cover local HealthWatch organisations from across the country, and that representatives are elected through due process for an appropriate term and with appropriate accountability. We know that this works very well. We have seen regional elections to national bodies in the voluntary sector and even outside it, from student unions, to national professional associations, to the National Association of Citizens Advice Bureaux. The National Association of LINks Members recently conducted elections from its regions which were overseen externally and the process proved to be satisfactory.

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5.15 pm

My Amendment 308B places an obligation on the CQC to have due regard to the advice given to it by HealthWatch England in all its functions. This advice will have equal status to that of the CQC's current advisory committee established by the 2008 Act. If HealthWatch England is to have any teeth, it would be illogical for it to have lesser status. Due regard means that the CQC must demonstrate how it has incorporated the advice of HealthWatch England into its conclusions and actions, embedding reality into the way it applies theory.

This will open the way for HealthWatch England to comment in its report on whether the CQC has taken note of its advice, as required by new Section 45B. New Section 45A(6) only requires the CQC to respond to advice from HealthWatch England and not take any account of the way it goes about its business of regulating health and social care. This is inadequate and does not incorporate the voice of patients and the public in regulation.

Finally, I say that we should learn from past disasters and failures in the NHS. A powerful lesson from the Bristol inquiry was how important it is to involve patients and the public. Recommendation 160 from the inquiry stated:

"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".

I would not be surprised if the second Francis inquiry states something similar. Of course, I do not know what it will say-this is just a supposition on my part. It would be good for the Government to show that they are ahead on this and that they understand the importance of these issues and are taking action through mending the Bill. If my noble friend Lady Northover is not totally convinced by my amendments-I hope that she will be, but probably she will not-perhaps she will take them away and at least give them serious thought, because I think they have merit. They will give HealthWatch England a sound basis on which to maintain some independence while still being in the tent and therefore in a strong position to influence the CQC and secure continuous improvement in the provision of healthcare.

Lord Whitty:
My Lords, I, too, tabled amendments in this group. They are aimed at providing HealthWatch with the independence and resources that it requires to genuinely represent the patients and users of health and social care services. Many noble Lords will understand that I am not a health service expert. However, when the White Paper proposing these changes came out, I still had some responsibility for consumer affairs generally as chair of Consumer Focus. Health service professionals do not like to regard their patients as consumers-I am quite happy to call them patients, users or clients-but we are moving the users of health services to a situation closer to that of consumers in other markets.

If we do not have separate consumer representation that reflects at both local and national level the concerns and interests of those consumers, we will not improve the service in the interests of users and patients. The

noble Baroness, Lady Cumberlege, tabled amendments to strengthen the position of the regulator that go a considerable way towards making sure that there is some recognition of independence. However, the role of patient representation is entirely different from that of the regulator. Inevitably there will be conflict.

I turn to other sectors. When I was the Minister responsible, we took the Consumer Council for Water out of Ofwat because there was a conflict. We took out Passenger Focus from what became the Office of Rail Regulation because

there was a conflict. We always kept Energywatch and then Consumer Focus separate from Ofgem. There was tension in all those areas, but that tension is more easily resolved if there is independence, ring-fenced funding and an ability to relate directly to the consumers of those sectors independently of the regulator. There is not a huge amount of difference in the health service, although obviously there are some esoteric aspects to it. The question of price and the exchange of money at the point of service does not arise in the same way, but questions about much of the rest of customer service absolutely do arise. Indeed, the main complaints about the health service are related to customer service and are almost equivalent to those made in many private and public sector markets.

I do not accept that a role within a regulator is sufficient to represent the interests of patients and users. Many of the propositions that are before noble Lords are worthy of the Government's consideration. My own proposals are based very much on the construction of Consumer Focus, and in that sense they are not my own work but the work of the parliamentary counsel at the time. They are in no way superior to my noble friend Lord Harris's jottings. If we were to look at them all together I am sure that those of us who are arguing for independence could come up with a clear alternative, but it would be much better if the Government themselves recognised the strength of argument in this area and came up with their own proposition between now and Report. They need to make it fit with the total pattern. The Government are the only people who can make a commitment to resources and to genuine independence. After the strength of argument that has come up in this debate, and with the views from LINks and from some of the patient organisations for particular conditions and diseases that the present proposals inadequately reflect, I hope that the Government will think again.

My last point is that, in addition to independence and to separate and clear resources free from the provider and the regulator, the Government need to look at powers, because a genuinely effective consumer, user and patient organisation that does not have the power to request from the providers, and in this case the commissioners, information on how they are conducting their affairs is always at a disadvantage. In other sectors there are clear powers for the consumer organisation. In this sector I am sure that those powers are also necessary for the whole range of bodies which the new configuration of the health service will have as a result of this Bill.

I hope that the Government think about this debate and come up with their own proposals. In the mean time I support the noble Lord, Lord Patel, and others who have spoken in the debate.

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Lord Walton of Detchant:

I have a short but, I believe, relevant question for the Minister. As he is aware, a medical charity called HealthWatch has existed for some years. I have the honour to be a patron of it. Every quarter it produces incisive commentaries on health matters that are not always totally in line with government policy. Has the department been able to work out some kind of mechanism by which any potential confusion in the public mind between the charity and this body, which is to be created under this Bill, can be avoided?

Baroness Masham of Ilton:

My Lords, I want to ask the noble Baroness, Lady Cumberlege, about her safeguarding amendments, which are very interesting. Would she not also put down a safeguarding amendment about the funds? Jobs will not be able to be done unless funds are safeguarded.

Baroness Cumberlege:

I will think about that. Having dealt with the Treasury in the past, I know how difficult it is to get anything ring-fenced. However, the noble Baroness's suggestion is very interesting and I will take it on board.

We have examples of other consumer groups being very effective within their parent organisation. I think in particular of NICE, which has done a lot to get views on its work from the general public. The Council for Healthcare Regulatory Excellence has also done that.

Lord Harris of Haringey:

I am sorry to intervene again on the noble Baroness, Lady Cumberlege. It is probably because we know each other too well that I feel able to interrupt at regular intervals. The examples she has just cited are examples of bodies that are there specifically to advise the organisation concerned. The consumer panels that NICE set up are about advising NICE about particular issues in terms of clinical effectiveness and what patients in that area are concerned about. They are not representing patients more generally and they are certainly not representing patients in terms of the statutory obligations of NICE and where there might be a

disagreement about what NICE is doing. They are there to inform. That is the distinction.

Lord Patel:

In response to the amount of funding, as I understand it-I am sure the noble Baroness, Lady Northover, will correct me if I am wrong-the Bill suggests that the funding for HealthWatch England will be a grant in aid provided by the department to the CQC.

Baroness Jolly:

My Lords, they say that too many cooks spoil the broth, but I think this is an occasion where that probably has not happened. Many hands might make light work. I ask the Minister to take these amendments away because there is an awful lot of good to be found in each of them, but not in each together, as it were.

Amendment 318C, tabled by the noble Lord, Lord Whitty, inserts a new clause and subsection (2)(a) of the new clause is about complaints. It is a nice idea

that complaints could be taken to HealthWatch England. Complaints are a big issue to which we will be returning on Amendment 108.

The noble Baroness, Lady Cumberlege, raised the relationship between local and national HealthWatches. It is critical. We would support the election of local HealthWatch representatives to the national body.

Finally, on independence and finance, I believe very strongly that it is very difficult to criticise and challenge an organisation if you sit within it. I understand the point about the benefits, but if you are local, and you sit within your local health authority or nationally you sit within the CQC, generally the feeling that you are monitoring the organisation that is your host is never a good place to start. Similarly, I, too, have had letters from people who were CHIPs and then LINks about budgets being not just cut a little bit but absolutely hacked away. I would be really uncomfortable if, for example, locally the HealthWatch was going to be located within the principal local authority that held the budget. We have had it already today. Intentions will be good and then somebody will come along and say, "We really need a bit more just for this". It will happen in a meeting where they are not present and, all of a sudden, there will be another slice taken. We have seen it before with lots of other things. You could look at it from a negative

point of view and say these are like curate's eggs and bad in parts or good in parts, but I think too many cooks will not spoil this broth. Many hands will make light work. I ask my noble friend to take this away and have a look at it.

Baroness Northover:
My Lords, I sympathise with the noble Lord, Lord Patel. He is forgiven for being subject to the beatings of the noble Lord, Lord Harris. When I made my maiden speech, the noble Lord, Lord Harris, gave me a very interesting and less than usual tribute. Noble Lords will see that we have a slight history.

Lord Harris of Haringey:
The noble Baroness stood against me.

5.30 pm

Baroness Northover:
As the noble Lord points out, I stood against him as a paper candidate-a non-serious candidate. When I went up to congratulate him on winning by about 2,000 votes to my 20 or whatever it was, I was given a blasting in relation to the successful campaign of one of my colleagues. That apart, I have great respect for the noble Lord, Lord Harris, and I am very happy to discuss these amendments wherever they come in the Bill. However, I would point out that these amendments are about HealthWatch England and we will return to local HealthWatch organisations later on. I gather that the noble Lord, Lord Harris, will not be here at that point so has flagged up some issues which I hope to be able to address. But noble Lords may wish to be aware that we will be coming back to this in relation to the local aspects.

This has been yet another high-quality debate and a range of different perspectives have been expressed. One of the things that has come through is the concern about trying to make sure that the NHS is genuinely

patient-centred. All too often, patients are expected to fit around services, rather than the other way around, and that is what we are seeking to tackle here. Years back, I was a very junior spokesperson on health for the Lib Dems and then I moved to international development. I remember the debates on this issue, in particular on the National Health Service Reform and Health Care Professions Bill

in 2002. It is one of the things that I asked about when seeking a briefing. Various noble Lords have referred to what has happened over the years. I was interested in what the noble Lord, Lord Hunt, said in 2002 when he put forward proposals to involve patients. After they had gone back and forth and around and about and there had been much discussion, he described his position as being,

> "as good as it gets".-[*Official Report*, 13/6/02; col. 419.]

The noble Lord, Lord Harris, said that they now had a system,

> "which will act robustly in the interests of the public and patients".-[*Official Report*, 13/6/02; col. 430.]

I very much welcome the fact that the noble Lord, Lord Harris, recognises that we are trying to improve on things.

Lord Harris of Haringey:
It went down before it went up.

Baroness Northover:
Then there were the patient forums of 2004. The noble Lord, Lord Warner, said that these were,

> "the cornerstone of the arrangements we have put in place to create opportunities for patients and the public to influence health services".-[*Official Report*, 5/7/04; col. 516.]

In 2007, we moved on to LINks. We have abandoned the commission that was at the centre-the noble Baroness, Lady Cumberlege, referred to this-because it was centralising, bureaucratic and absorbed money that was supposed to be devolved. I have the Health Select Committee report criticising that commission.

As others have said, there is a history of trying to move this forward and trying to ensure that there is better patient and public involvement. I welcome what various noble Lords have said about the improvements in the Bill. We are trying to learn from that history and move it on, although I hear what people say that we possibly have not got it as far as they people wish.

The Government are seeking a fundamental shift. The aim of HealthWatch England is to help orientate the NHS first and foremost around the patient. HealthWatch, at both local and national levels, aims to strengthen the ability of service users and other members of the public to shape and improve health and

social care. The role that HealthWatch England will play is crucial. Its aim is to provide leadership, support and advice to local HealthWatch organisations and to make them more effective. I looked at the LINks reports and although they are welcome, anyone can see that there is much more that can be done. They do not reflect the whole range of patient voices and the kind of responsiveness you might wish to see in the health service, which is why it is such a challenge.

HealthWatch England will also provide information and advice about the views of patients, the public and local HealthWatch to the key players in the NHS

and social care-the Secretary for State, the NHS Commissioning Board, Monitor, English local authorities and the Care Quality Commission. At present there is no statutory body with either of these roles. Therefore, I am sure we can all agree that this represents a step forward. As noble Lords have said, the HealthWatch England committee will be a committee of the CQC, with a chair who we intend will be a non-executive director of the CQC. Part of this debate has focused on whether this is the appropriate organisational form for HealthWatch England: whether, in this form, it can sufficiently and independently serve the interests of patients and the public and whether it will have the status it needs to achieve this. I have listened to these concerns and I fully agree that this area is too important to get wrong. We are interested in change that works and this Government believe that setting up HealthWatch England within the CQC is the best way to achieve this aim.

I shall explain the reasoning behind this. First, there are key synergies to exploit here. To be effective, HealthWatch England is going to need extensive capabilities which the commission that existed before clearly did not have. It will need clout, which clearly that commission did not have. Being part of the CQC will enable it to have both of these. HealthWatch England will be able to draw on the infrastructure and support from the CQC to deliver its work to a high standard. It will have easy access to the CQC's information sources, which have been referred to, enabling it to develop a deeper understanding of how health and social care organisations are functioning or where there are problems where the views of people may have made a difference. Being part of one of the big national bodies will, we hope, give HealthWatch England a real profile, and one we feel would be hard to generate if it was a new, separate body-and there is the history that we know about. Operating from within the CQC should enable HealthWatch England to punch considerably above its weight.

Secondly, it will enable the voice of patients to have a real influence on the regulatory work of the CQC. Close working and communication between HealthWatch England and the CQC opens up the possibility of having the patient voice hardwired into the work of the commission. It is not just a matter of looking at HealthWatch England but seeking to ensure that it really has a positive effect.

Lord Warner:
Can the Minister give the House any information that the department has on the name recognition of the Care Quality Commission which would deliver the kind of profile for HealthWatch that she is claiming for it?

Baroness Northover:
The noble Lord, Lord Warner, is very concerned that HealthWatch itself is a name that is going to be far too easily recognised and obliterate his charity. This is HealthWatch. The fact that it is in that relationship with the CQC does not obviate that. I would turn it back to the noble Lord and ask him who might recognise any of those predecessor organisations over the past 10 years and whether there was ever wide recognition of those.

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Lord Warner:
That was not my question. The noble Baroness is arguing that HealthWatch would actually benefit from being hosted by or being part of the Care Quality Commission because it would be a powerful national body. I was asking the noble Baroness what the name recognition of that powerful national body was that would produce benefits for HealthWatch.

Baroness Northover:
At the moment the CQC is relatively well known because its reports are in the press fairly frequently. The reports of the investigations that it has been undertaking have caused considerable concern. I cannot give the noble Lord a scientific response based upon polling as to the recognition of the CQC, but I would guess that it is somewhat higher than some of the organisations representing the patient voice that have been there before. When patients went into hospital and had concerns about various things, did those organisations spring to the forefront of their minds? Possibly not.

Baroness Morgan of Drefelin:
I too have listened to this extremely important debate with a great deal of interest. I am slightly losing the thread of the Minister's argument. When the Minister started she was saying that the debate was about how we put patients at

the centre of the NHS. However, I think that the debate has been about whether or not HealthWatch England should be independent. What the Minister is saying is very interesting, and I do not want to interrupt her for too long. I want to understand what the benefits to HealthWatch England are of being enclosed within or subordinate to another organisation. If we want to have a HealthWatch England that is out there punching above its weight and really taking patient interests to the Secretary of State and the Commissioning Board, it would seem to have a much better opportunity to be heard, recognised and understood as an independent organisation that is not subordinate. Why do the Government think it is better to wrap it up inside another organisation which is very different in character, and make it dependent and subordinate to that organisation? How will that help it to fulfil its objective?

Baroness Northover:
I am sorry that I am not putting this clearly. One of the major points about this is for HealthWatch England to be in a place where it can have a direct effect upon organisations like the CQC. We know from history that even when you have a national organisation, it does not necessarily mean that it has the effect that one would wish; the noble Baroness will know that all too well. Various parts of this organisation have various obligations built in to listen to HealthWatch, which we hope will help, but because it is there as part of CQC there is an obvious relationship, because CQC is the organisation that goes in and regulates the institutions that deliver care. The CQC regulates; the various institutions and other bodies provide the care. HealthWatch England is trying to draw out the patient's voice in this, and make sure that it is heard loud and clear.

Fancy this; I have just been given a quote from the chief executive of National Voices, Jeremy Taylor, who says that he is,

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"not sure that it matters where HealthWatch England sits. What matters is whether it has clout, credibility, independence and sufficient resources. One could have a big debate about whether it should sit as a separate body or as part of the CQC. Colleagues may have different views. My view and the view expressed in the forum is that HealthWatch England will be an important part of the architecture for the patient voice, so we should welcome it."--[*Official Report*, Commons, Health and Social Care Bill Committee, 28/6/11; col. 67.]

Baroness Emerton:

My Lords, we have referred to "patients" all the time, and I understood that HealthWatch was going to be public and patients. The Care Quality Commission looks at complaints. There is a culture issue here. The independence of HealthWatch is vital, because we are talking about the future as well as the present. My experience over the years, when we have been looking at new services, is to have the public and patient representation coming forward with ideas-it should not be governed by a health authority or anyone else, but be independent-and reporting back to the body that asks the question. We are going a little off-beam in terms of the Care Quality Commission, which would be culturally oppressive to any organisation that is set up to look to the future.

Baroness Northover:
The noble Baroness is quite right that this is patients and public. One of our concerns about some of these amendments which refer only to patients is because the whole of the public are potentially patients, or related to or caring for patients and so on. It therefore does have to be defined widely, and she is right that we are looking to the future. I am not sure that I would share her view as to the CQC, which indeed needs to help play its part in driving up quality, which underpins much in the Bill.

Maybe I can carry on and address some of the specific points raised by noble Lords. The Bill preserves a clear distinction between the CQC and HealthWatch England. Although HealthWatch England will be established as a statutory committee of the CQC, it will be solely responsible for setting the direction of its own work and exercising particular functions. This will ensure that HealthWatch England targets issues and gathers evidence from the public to base its national advice on service standards and improvements. HealthWatch England will maintain its independent role by presenting the collective patient and public voice to the Secretary of State and to the relevant bodies.

5.45 pm

After listening to the concerns raised about the importance of reinforcing the distinction between the roles of the CQC and HealthWatch England, the Government made an amendment to the Bill in the other place that requires the CQC to respond in writing to the advice it receives from HealthWatch England. Similarly, HealthWatch England must publish a report on the way it has exercised its functions during the year and lay a copy before Parliament. This will be a distinct report by-and the responsibility of- HealthWatch England, as opposed to the general CQC report.

The noble Lord, Lord Patel, suggested that local HealthWatch would have no direct influence on CCGs. Let me see if I can answer some of those issues which have been raised in relation to local HealthWatch. I cannot agree that this is a fair representation.

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Local HealthWatch will have the function of making known the views of people and making reports and recommendations for service improvements to commissioners of local care services, among others. This is set out in Clause 180, which amends Section 221 of the Local Government and Public Involvement in Health Act 2007.

The noble Lord also suggested that HealthWatch England should have regional arms. I cannot agree with him that this would be a good course of action. We want to see resources, wherever possible, channelled to the front line. One of the criticisms of the short-lived Commission for Patient and Public Involvement, which I have referred to before, was that this was too bureaucratic and its regional arms soaked up too many resources. We feel that having both a local and a national tier is sufficient. The noble Lord, Lord Patel, also asked about research. Local HealthWatch will gather and present the views and experiences of local people to make reports and recommendations, and as part of this it may need to carry out studies. However, we have to remember that it is not primarily a research organisation. We have to emphasise that it is a champion of patients at local level.

Lord Patel:

I did not have in mind the scientific meaning of "research". This is research of what is going on in individual hospitals. I use the example of Mid Staffordshire, where it was the research following initial incidents that made everybody aware of the extent to which bad practices were going on. That is the kind of research that local HealthWatch should be involved in.

Baroness Northover:

I take on board what the noble Lord says, and indeed he is absolutely right. There are various ways in which such problems should be picked up, but it is exceedingly important that that happens, and we certainly hope that local HealthWatch will be part of that.

The noble Baroness, Lady Wheeler, talked about engagement with stakeholders. I can assure her that there is ongoing engagement with stakeholders through a

HealthWatch advisory group. The National Association of LINks Members and others are members of this group, and there are others. The noble Baroness also asked about the funding for transition. The Government continue to make funding available to LINks- £27 million during the transition-and as part of the HealthWatch development programme we will make £3.2 million available for start-up costs for local HealthWatch organisations.

The noble Lord, Lord Harris, asked about conflicts between the CQC and HealthWatch England. We disagree that the Bill does not already provide sufficient safeguards to ensure the independence of HealthWatch England within the CQC. Obviously, in extreme cases, the Secretary of State has the ability to intervene if HealthWatch England is significantly failing. However, both the CQC and HealthWatch England have responsibilities that they must deliver.

The noble Lord also spoke about the relationship between LINks and local authorities, and expressed some concern about that. LINks have been funded by

the local authorities and it is right that so too will the local HealthWatch. The relationship of local health authorities and LINks overall has been a successful one-although I take the point that he makes-that has encouraged collaborative working between LINk and the local authority. The Government believe that if local HealthWatch organisations are to play a full part in their local communities, it is appropriate for them to be accountable to directly elected local bodies that are better able to assess the needs of the local population. It would not be appropriate for them to be funded nationally, but I hear what the noble Lord said.

My noble friend Lady Cumberlege spoke strongly in support of many of these developments from her knowledge of the history of the past few years. She showed how we are trying to build on the experience of previous Governments to take this forward. However, she will not be surprised to know that I have some concerns about some of her amendments. Her Amendments 307A and 308A would prescribe certain aspects of the membership of the HealthWatch England committee. For example, Amendment 307A proposes that:

"The majority of the members of the HealthWatch England committee shall not be members of the Commission".

The debate that we have just had illustrates why this is important. Certainly, we have sympathy with that point of view. However, we do not think that it should be in the Bill. It is best to put these in regulations, which would enable flexibility.

Clearly, rules about the membership and procedure need to be consulted on and that will be taken forward when we engage over those regulations.

I told myself that we would write to the noble Lord, Lord Walton, about his organisation. However, it turns out that I am aware of a number of other organisations that use the name HealthWatch. The Government's proposals mean that the HealthWatch we envisage will be unique as the champion of the patient and the public voice. I am not sure whether that totally answers the concern of the noble Lord, Lord Walton. Perhaps I had better write to him after all.

My noble friend Lady Jolly flagged up concerns about complaints. Perhaps I may reiterate that HealthWatch England's role is that of a national champion of the consumer voice. Its purpose will be to bring that voice to the attention of regulators and others. Giving HealthWatch England powers of investigation of complaints could compromise its primary role in that regard. One of the developments introduced by the previous Government was to bring in a statutory framework for an investigation of NHS and adult social care complaints. It remains the Government's view that complaints are best dealt with in the existing framework and initially at the local level. This provides a better opportunity for local organisations to learn from their mistakes and to improve services as a result. Where resolution is not possible locally a complainant is able to complain further to the Health Service Commissioner, the ombudsman or the local government ombudsman, as appropriate. The ombudsman's functions of investigation are statutory. Therefore, we see no reason to duplicate. The structure set in place by the previous Government will stay in place and acts in that way.

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As ever in this House there is a wide range of experience, particularly perhaps in this instance on what has not worked in the past. It is a great challenge to enlist patients and the public in making sure that standards are driven up. We believe that devolving to the local level with clinicians and patients more in the driving seat should help. I welcome the support of noble Lords who feel that these changes are a move forward, but I hear them when they say that there are areas that still need to be addressed. For that reason, we would certainly like to continue discussions with those who wish to feed in on this issue in order to make it as good as we can: namely, a system that more effectively brings to bear

the voice of patients and the public, which has so far proved to be a difficult challenge not only to the previous Government but to Governments before that.

Lord Patel: My Lords, I was hoping that at the end the noble Baroness would be able to say more strongly how the Government intend to take forward today's debate, but I am afraid that she did not do that, which is a pity. There was strong support for HealthWatch England and local HealthWatch to have more independence. Her argument about a synergy between the CQC and HealthWatch England is not absolutely correct. Yes, there is a degree of synergy, but not in all areas, including: commissioning, as mentioned by the Minister; community care, where the CQC is not involved; advice to the Secretary of State on the mandate; and social care as it develops to more home-based care where the CQC will not be involved. HealthWatch England has a much wider remit than the CQC.

I have a rule in life never to oppose anything that the noble Baroness, Lady Cumberlege, says or does and I will not break that rule now. She is always well researched and communicates her research well, but I have to say that her well researched argument supports the Government more and I am surprised that the noble Baroness, Lady Northover, did not feel able to accept some of her amendments. None the less, it is a halfway house that would give more independence to HealthWatch England within the CQC. If we are serious about giving HealthWatch England independence, it should be truly independent. It should have its own powerful voice for the public and patients. It should not be answerable to another body that will control it, fund it and employ its members. That is the great weakness.

The outside voice of the people involved in this work is strong. They would like to test their work in an independent way. Previously, they have failed because they have not been given that independence. Let us be serious about giving a strong voice to the public and patients. Let us give them independence and see whether they can stand up to the challenge.

There was a lot of support today but I am willing to continue talking, particularly with the outside organisations, if that commitment can be made by the Government. We will always have an opportunity to come back. I beg leave to withdraw the amendment.

Amendment 99 withdrawn.

Amendments 99A and 100 not moved.

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Amendment 100A

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

100A: Clause 20, page 16, line 30, at end insert-

"( ) If, within 60 parliamentary days of the mandate having been laid-

(a) either House of Parliament makes a recommendation with regard to the proposal, or

(b) a committee of either House of Parliament makes recommendations with regard to the proposal,

the Secretary of State must lay before Parliament a statement setting out the Secretary of State's response to the resolution or recommendations."

Lord Hunt of Kings Heath: My Lords, the debate on the first group was instructive on the relationship between Parliament, the Secretary of State and the mandate that the Secretary of State sets for the NHS Commissioning Board. In our final exchange the noble Earl said that he was fearful of Parliament micromanaging the National Health Service. My fear is that that is shorthand for saying that Parliament may be told that it will no longer be able to ask detailed questions about the NHS because it is covered in the mandate. Whatever it may be, the mandate assumes critical importance since it lays out the objectives set for the NHS Commissioning Board by the Secretary of State. My amendment is not about micromanagement, it is about proper parliamentary scrutiny of what the Secretary of State has decided, and it sets out a well tried procedure. The final decision on the mandate will remain with the Secretary of State, but it will allow Parliament to undertake proper scrutiny. I beg to move.

6 pm

Division on Amendment 100A

Contents 201; Not-Contents 220.

Amendment 100A disagreed.