Health and Social Care Bill

Bill Main Page

Report (1st Day)

3.36 pm

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

Motion

Moved by ***Earl Howe***

That the Report be now received.

Lord Owen: My Lords, before the House agrees that the Report should be received, I would like to raise some important constitutional questions. On 4 April, the day the Prime Minister and the Deputy Prime Minister embarked on their "listen and explain" experience and the legislation was paused, I wrote to the then Cabinet Secretary, Sir Gus O'Donnell-now of course the noble Lord, Lord O'Donnell-and raised with him the fear that, because of the long drawn-out legislative process, discussion of the Bill in this House could be pre-empted. I also told him that I had consulted the clerks in Parliament and it appeared that there was no written convention that guides the Government on what is or is not acceptable to take in advance of Royal Assent. Obviously they cannot implement the legislation in full.

Many of my concerns since then have been more than justified. I received a letter on 7 April from the then Cabinet Secretary that said:

"The Treasury guidance on 'Managing Public Money' sets out how, in some circumstances and if ... conditions are fulfilled, departments can incur expenditure on the measures contained in a bill prior to Royal Assent. In addition, a department may take steps to prepare for implementation using existing statutory powers. I have therefore discussed your concerns with Una O'Brien, as Accounting Officer, in the light of this guidance. She has confirmed"-

this is important-

> "that the work currently underway is taking place under the broad powers of the Secretary of State and NHS bodies under existing legislation. For example, the arrangement of PCTs into management clusters and the creation of pathfinder

> consortia are possible under existing powers in the National Health Service Act 2006. In addition, some of the changes currently taking place would be required regardless of the Health and Social Care Bill. For example redundancies in PCTs reflect the longstanding challenge, which pre-dates the Bill, to deliver up to £20bn of efficiencies across the NHS over the next four years for reinvestment in frontline services".

As a result of that, there has been broad acceptance in this House that on these controversial questions, some of which are already agreed, the Government are proceeding under existing legislation.

On 16 September I was informed by the chairman of the Constitution Committee that that committee had briefly discussed the pre-legislative disappearance of PCTs, and had in front of it my correspondence with the Cabinet Secretary, which I had made available to Professor Tomkins, one of its advisers. I was asked whether I would provide more information about changes that had been introduced following Second Reading of the Health and Social Care Bill but prior to it coming to the House of Lords. I enclosed an up-to-date document in great detail that had been sent out for consultation by the Midlands and East Strategic Health Authority, which I thought gave a pretty clear indication

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of the anticipated massive changes to the whole architecture of the NHS, many of which seem as if they will be introduced despite the fact that the full legislative process was continuing.

I also drew attention to a speech that had been made in the other place by a Member of Parliament that had again raised the question of whether it was proper to stop the legislation when so much was already being done and so much pre-emption had occurred. Today I have written to the Constitution Committee on this question because an MP drew my attention to a letter that says that people,

> "are absolutely terrified of the chaos that will apply if the Bill is dropped altogether now. Restructuring is a nightmare, un-restructuring could be even worse!".

On today's "World at One", the chief executive of the Foundation Trust Network warned of a no-man's land if the Bill did not go through.

This raises pretty big questions for legislation that is still to go through all its stages in this House, and it is a matter of great concern to this House when it considers reform. These conventions will become very much more important if we have an elected House of Commons-which of course we have-and an elected House of Lords, which I personally would like to see. There is no question that these conventions are important.

There are two important points here. First, the House should be aware of the fact that the Constitution Committee is seized of the problem and may well wish to make judgments on it. Secondly, we should not feed the idea that legislation can reach us but we cannot do anything about it because it has already been pre-empted. Whatever our views on the Bill, and it is controversial, it is important on democratic grounds that we maintain the position that legislation does not have full authority until it has gone through all its processes. That point needs to be reaffirmed. We should give no comfort to the opposite view in what we say in this House in the remaining stages of the legislative process.

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, of course, the noble Lord, Lord Owen, had no obligation to give the Government advance notice of the issue that he has just raised. Nevertheless, I am sorry that he did not. I just say to him that everything that has happened to date in my department's implementation of the transition programme has been done under the Secretary of State's powers under the 2006 Act. This is all proper and lawful. However, this can go only so far. It is not a permanent solution, hence the need for the primary legislation that we are now debating.

It has been the practice of successive Governments, once a Bill has passed through the other place, to do as we have done and make preparations for that Bill's implementation. The previous Government did it on a number of occasions and we are doing so as well. Furthermore, we are doing so in a measured and structured way. It is not an overnight process-it never could be. It is being done over a period of years. It in no way pre-empts the will of this House, which has made its views, to which the Government have listened very carefully, known on a number of issues.

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While thanking the noble Lord for raising this concern, which I shall of course consider very carefully, as I always do, I hope the House will feel that it is unconstrained in how it

presents amendments to the Government and how it argues for them. We, in our turn, will respond in a constructive manner, as I hope always to do.

3.45 pm

Baroness Thornton: My Lords, I think the noble Earl has answered the question as far as it goes, but he raises several points. First, this Bill did not need to be in front of us at all because many of the changes that are taking place do not need primary legislation. Secondly, his colleagues in another place have constantly said that the Bill cannot be dropped because it has gone too far. We are not in the same place now as we were at the end of Committee; millions of people in the health service have now expressed their view that this Bill should not happen at all. Given that, do the Government have a plan B in case they need to withdraw the Bill? Do they have people working on that in case the Bill has to be dropped?

Lord Warner: My Lords, before the Minister responds to that question, will he consider later-if he cannot answer now-the budgets for clinical commissioning groups? I understand from a meeting of the national Commissioning Board, which was held in open session on 2 February, that Sir David Nicholson is reported as having said that clinical commissioning governance is, in effect, moving on apace, and that more than 95 per cent of clinical commissioning groups have now agreed their constituent practices and geographies and are already seeing benefits in their services from the work that they have been doing. At the high level, around 50 per cent of the commissioning spend is already delegated to clinical commissioning groups from PCTs under various delegation schemes. That seems fair enough, but there is a final point on which I would welcome the noble Earl's clarification. It says that the ambition is for all this to be so delegated to clinical commissioning groups by 1 April 2012. Will that delegation still be part of the present powers, or is it in anticipation of the legislation being passed in time?

Lord Howarth of Newport: My Lords, has the noble Lord, Lord Owen, not drawn our attention to a particularly egregious example of a problem that is, however, long-standing? Have successive Governments not taken the will of Parliament for granted following Second Reading of measures and begun to spend money and implement transitional arrangements on that basis? Has it not always been improper, and should Governments not be particularly careful when they are well aware that the policies embodied in their legislation are highly contentious? I hope that we may hear some considered reflections by the Government on the generality of this practice, as well as on this particular incidence. It may be that the relevant Select Committees of both Houses of Parliament will want to consider this problem.

Earl Howe: My Lords, in answer to the noble Baroness, Lady Thornton, there is no suggestion that the Bill could be withdrawn. We are clear that it is the

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right thing to do. Reform of the NHS is necessary and in the national interest, and the measures in the Bill represent the best way forward.

The noble Lord, Lord Warner, asked me about the powers of delegation. All I can say to him is that the delegated budgets to which he referred are delegated under existing powers, so there is no issue in law if that is what he was implying. However, I will endeavour to write to him if I have any further details for him on the subjects that he talked about.

The noble Lord, Lord Howarth, suggested that the Government were beginning to spend money. In one sense he is right because there have been redundancies in the NHS, but in another he misses the point. We have started to save a great deal of money. These measures will save £1.5 billion every year from the end of this Parliament and around £3.2 billion during this Parliament. We have begun to implement efficiencies and improve patient care at the same time. I hope he will look at these issues in the round.

Report received.

Clause 1 : Secretary of State's duty to promote comprehensive health service

Amendment 1

Moved by ***Lord Patel***

1: Clause 1, page 2, line 6, after "of" insert "physical and mental"

Lord Patel: My Lords, it is a dubious privilege to speak to this amendment. I say "dubious" because the noble and learned Lord, Lord Mackay of Clashfern, is on a well-deserved rest and recreation leave and the noble Baroness, Lady Hollins, who is better qualified than me in this area, is unfortunately also detained on a lecturing commitment in Rome. However, I am pleased to say that the noble Lord, Lord Alderdice, whose name is also to the amendment, and who is much more knowledgeable on these matters than me, will no doubt speak later.

The House will remember that when we discussed this issue in Committee there was widespread sympathy for and acknowledgement of the need to recognise mental illness

and accord it a similar importance as that accorded to physical illness. The noble and learned Lord, Lord Mackay of Clashfern, who tabled this amendment, wrote a note to me to say he was sorry that he would be away when it came up for consideration. He said that some time ago he was travelling with a lawyer colleague who had been a chairman of mental health tribunals for many years. He asked his colleague what was his impression of progress in this field. The reply was that it was not great compared with that in other health fields. The noble and learned Lord's view is that it is desirable to emphasise the importance of mental illness and its treatment for the well-being of our people, and that it is wise to do so through this amendment to this comprehensive Bill. He feels right at the start of the Bill is vital to place to do so. Thereafter, the definition clause will carry this meaning where appropriate. The noble and learned Lord does

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not agree with the objection that if the provision is inserted at this point in the Bill, it must be inserted everywhere the issue arises. In his view, the definition will carry that burden and make later repetition unnecessary.

The amendment would place an explicit duty on the Secretary of State to promote parity of esteem between mental and physical health services. The duty would sit within his or her existing duty to improve the quality of health services. It also clarifies that the Secretary of State has a duty to promote a health service designed to secure improvements in the prevention, diagnosis and treatment of both physical and mental illness. The amendment would put the Government's own commitment to parity of esteem between mental and physical healthcare on a statutory footing and make it clear that the Secretary of State is fully committed to improving the nation's mental health services and the prevention and treatment of mental and physical illness and expects the NHS board and the CCGs to do the same.

When the Government launched their mental health strategy, *No Health WithoutMental Health*, in February 2011, the Minister for Care Services stated that he wanted to see parity of esteem between mental health and physical health services. This was a recognition of the fact that, despite the prevalence of mental illness-one in four people experience a mental health problem during their lifetime-mental health has never received the funding or attention it needs. Progress in improving the quality of commissioning and services has been much slower for mental health. Parity of esteem is not defined in the document itself. However, it would be reasonable to expect that this would mean a recognition of the equal importance of mental and physical health and the need to consider both aspects of people's health when they present with either physical or mental illness. I would expect this recognition to be evident in terms of

access to mental health services and funding for services proportionate to the disease burden. However, this has not been the case.

Over the past 10 years things have begun to improve. For example, we have seen significant and very welcome investment in talking therapies under both the present and previous Governments-£173 million in 2007-10 and £400 million from 2010-14. However, given that mental health services started from a very low baseline, we simply cannot afford to go backwards-and talking therapies are only one aspect of mental healthcare. During previous spending squeezes-for, example during the financial year 2005-06-mental health services have been unfairly and disproportionately targeted for cuts, perhaps because they do not enjoy the same level of public support and understanding as other services. I admit that I often push for cancer services and maternity services, so I pay regard to that.

However, mental illness is a leading cause of suffering, economic loss and social problems, and it is time to recognise and act on the plentiful evidence that good mental health underlines all health. Poor mental health is associated with diseases such as cancer, cardiovascular disease and diabetes; and poor physical health increases the risk of mental illness. In the current climate of scarce resources, expenditure reduction, welfare reform

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and cuts to legal aid-I might as well get all that in-mental illness and mental health problems are likely to increase. However, while mental illness represents 23 per cent of the disease burden, it accounts for only 11 per cent of the health budget. It is therefore vital that mental health spending should be proportionate to the need, and mental health must not be the poor relation of physical health.

More than one-fifth of the population in England experiences a mental disorder at any one time. An even larger proportion experiences sub-threshold mental disorder. Almost half of adults experience at least one episode of depression during their lifetime. Only a quarter of affected individuals receive any intervention, except those with psychosis. Compared with people with no mental health problems, men with severe mental illness can expect to live 20 years less, and women, 15 years less. A combination of lifestyle risk factors such as smoking and diet are higher, as are unnatural deaths such as those caused by suicide and accidents. Poor physical healthcare contributes to this premature mortality. If such a disparity of mortality rates were to affect a large segment of the population with less stigmatised characteristics, we would witness an outcry against the socially unacceptable neglect of that group.

While the amendments cannot solve all this, creating an explicit duty on the Secretary of State would set a clear expectation that commissioners need to give full consideration to the mental health of those with physical health problems, and to the physical health of those with mental health problems-and to give full consideration to mental as well as physical health. It is simply not acceptable for the mental health needs of children and adults to continue to be neglected.

There is an imbalance between mental and physical health in both healthcare and health promotion in many places. A better balance could bring a number of benefits to people living with, or facing the risk of, mental ill health. Health and social care policy should be developed with mental as well as physical health needs in mind. A duty to promote equality should encourage policymakers at all levels of the system to consider mental health alongside physical health, rather than making policy for the latter, and later adjusting to fit the former.

I know that the Minister is very involved with people in the area of mental health because I know that he has been a patron of several charities related to it, and he therefore has great sympathy towards recognition of mental illness and its treatment. I hope that his answers to the amendment will be such that there will be no need to seek the opinion of the House, and I look forward to his reply. I beg to move.

4 pm

Lord Alderdice: My Lords, the noble Lord, Lord Patel, has characteristically underplayed his own grasp of this important area, but, as noble Lords have heard, he has on his own behalf and on behalf of the noble and learned Lord, Lord Mackay of Clashfern, and the noble Baroness, Lady Hollins, presented an elegant, informed and very persuasive case for the

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amendment, to which I have put my name. In many ways, there is not much to say other than to support him. However, when noble Lords say that in your Lordships' House, it is often because they actually have quite a lot to say, and I shall say a few words.

On 2 November last year in Committee, your Lordships debated three amendments which would have placed the responsibility on the Secretary of State, the national Commissioning Board and all clinical commissioning groups to regard mental health on the same basis as physical health. That is to say that they should give full consideration to all those suffering from mental illness in the same way as they would those suffering from physical illness.

One reason for trying to insert such a commitment into the Bill was that, despite the efforts of the previous Government-to whom the noble Lord, Lord Patel, is quite right to pay tribute-to address the needs of people with mental illness by allocating more money for talking treatments, on which the coalition Government have substantially built, as the noble Lord said with reference to the legal friend of the noble and learned Lord, Lord Mackay, out there in the real world, mental illness and problems of mental health do not get the same attention and concern. As we said in the debate in November, many people think of mental illness as a subset of illness, like cancer, diabetes, or whatever, but it is not. It is a quite different aspect. When you fall ill with something physical, something happens to you but your personality and your self are not affected; but when you fall mentally ill, the very essence of your self is affected. That is a very different business. It frightens people. They often turn away from paying attention to it because they are so troubled by it. The provision required is different. Often, much more than is the case with other illnesses, a whole range of services has to come together to provide treatment and support.

Our concern in that debate-which was supported by noble Lords on all sides of the House; no one spoke against-was that all the efforts until now have been less than fully successful in building up the regard and esteem in which mental health and mental illness is held. So the proposition for the amendments was not a belief that there was a particular technical flaw in the Bill which meant that mental illness would not be addressed; we are very much aware that it is addressed in the Bill. That is not the problem. The problem is: how do we find a way continually to bring mental illness to the attention of commissioners? The noble Lord, Lord Patel said, as was said in the November debate, that in times of financial pressure and austerity, the tendency is to pull back financial commitment from those areas where there is least pressure. When people are physically ill, they can often nevertheless continue to exert pressure; but when people are mentally ill, they often do not give due regard to themselves, never mind press for the needs of others who are suffering from similar disorders.

Our concern is not about those three specific amendments but the principle. The noble and learned Lord, Lord Mackay of Clashfern, went away and produced a single amendment. The noble Earl was kind enough to give a considerable amount of time to

me and the noble Baroness, Lady Hollins, to discuss the question. A concern was expressed by him and some people in the department that if one included this in one place, one would have to put it in every place because otherwise the implication would be that it applied only to the issue to which it refers directly. I have to say that the noble

and learned Lord, Lord Mackay of Clashfern, was wholly unimpressed with that argument. As he is a former Lord Chancellor, I think one takes that pretty seriously.

The point is that we must find some way in which to make it absolutely clear beyond peradventure that concern for those who have mental health problems is every bit as great and the responsibility on commissioners is every bit as great to ensure the proper provision of services. One reason why this comes up as the very first amendment at Report is that we want to ensure that in all aspects of health care, mental health care is attended to: no health without mental health and indeed, as the Royal College of Psychiatrists' report said, no public health without public mental health.

It is regrettable that the Royal College of Psychiatrists, of which I am a member, has over the past few days been saying that the whole Bill should be set aside. That is not really a helpful way of engaging in these kinds of questions. The college knows perfectly well that the Bill is not going to be set aside-in fact, it would not be at all helpful if it were. I have seen these kinds of situations in other places, with people polarising in an unhelpful way. I appeal to the Minister, to the Royal College of Psychiatrists and to others who are interested and concerned in this field to find a way to get together again before the completion of the Bill to ensure that the concerns that we are expressing are reflected in a cast-iron fashion. It is a question not of these particular words or of this particular amendment but of receiving solid assurances so that we and those who care for people with mental illnesses, as well as those who suffer from such illnesses, can be confident about the new NHS.

Lord Walton of Detchant: My Lords, in rising briefly to support the amendment so ably proposed by my noble friend Lord Patel and supported by the noble Lord, Lord Alderdice, I ask the Minister one very simple question. In Clause 1(1)(a) the Bill talks about the,

> "physical and mental health of the people of England",

and says that the health service must be "designed to secure improvement" in that health. What on earth could the objection possibly be to inserting in paragraph (b) at line 6 the unexceptional words listed in the amendment? They simply stress the crucial importance of mental as well as physical illness. How on earth could this be construed as doing any damage whatever to the Bill? It is something that I hope very much the Government can be persuaded to accept.

Lord Carlile of Berriew: My Lords, I should like to say a word on behalf of those who have had to care for family members-often a young member of the family-who have suffered from severe mental illness. Those who have suffered that experience-and I am

one-know how marooned they feel when they find that someone in their family has a serious mental illness. If somebody

has a broken leg, you can locate the leg and take the medicine. If somebody has even cancer, it may not be curable but at least you have the knowledge of the location or locations of the cancer and the topical treatment that is to be applied to it.

The problem for families who experience in their midst mental illness is that no medicine can be applied topically to the place where the hurt or illness is taking place. The prognosis is uncertain, the mortality rate is depressingly high and usually at the hands of the sick person, and accessing good health service facilities is quite chancy, I am afraid. There is a real postcode lottery with mental health treatment. If, for example, you live in a remote rural area, only some therapies will be available and they may be the wrong therapies, particularly if the patient is a child or adolescent suffering from serious mental illness. Therefore, I simply say to the Minister who, as has already been said, cares deeply about these issues, that the adoption of this very simple amendment, as the noble Lord, Lord Walton, rightly described it, would send out such a telling message of support to families who have to care for people who suffer, perhaps temporarily, from mental illness that it would be seen as a declaration of purpose by this Government.

Baroness Whitaker: My Lords, briefly, from a lay perspective, I urge the Minister to take this amendment very seriously. I will not rehearse what I said at Second Reading from my experience on the board of the Tavistock and Portman clinic or from other walks of life about how widely damaging and destructive it is not to have parity, and how it needs to be explicit parity to change culture and to erode the stigma and the neglect associated with mental ill health. If the Government are rash enough not to accept the amendment-and I am quite sure that the noble Earl is not like that-I hope that there will be a Division. If the debate lasts until five o'clock, when I am committed to chairing a meeting, I hope that the House will accept my apology but I will return to vote.

Lord Newton of Braintree: I have two excuses for speaking. First, I have chaired two mental health trusts and, although I no longer do so, I have a continuing interest of a non-financial kind. Secondly, before my noble and learned friend Lord Mackay left for what was described as his well earned rest and recuperation, I was the nearest thing to anybody he anointed to take care of his interests while he was away, which includes this amendment.

I do not need to speak for long because I think that this is a no-brainer. Everybody agrees on the importance of mental health and endorsed the Government's *No Health*

Without Mental Health strategy. We are all keen on that-even the Government. Yet the little birds tell me that the amendment will be resisted on the grounds that it is not necessary and does nothing to add to the 2006 Act. I spent a lot of years as Leader of the House of Commons and I got fed up with Ministers who came to me on Private Member's Bills and other things and said, "It's not necessary-we are going to do this anyway". They then proceeded to immolate themselves on a bonfire for an amendment that would have cost nothing and done no harm-it certainly would not have added anything-but would

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have pleased a lot of people. That is idiotic. It would not cost the Government anything to do this and, as my noble friend said, it would please a lot of people, so we should simply get on with it. If my noble friend has been told to resist it I will sympathise with him, but frankly if the noble Lord, Lord Patel, feels that he should push it, I will push it with him.

Baroness Meacher: My Lords, I support this amendment very strongly and shall speak extremely briefly. Others have spoken most eloquently and very much made the case. My fear, too, is that the Minister will regard it as unnecessary. I have absolutely no doubt at all about the Minister's commitment to mental health, but I believe that this is necessary because of the context in which the amendment is being posed-in other words, the Bill itself. What I mean is that the Bill is designed more than anything else to introduce privatisation of the NHS-slowly, slowly. It will not be done overnight, but in 10 years' time we can be sure that a substantial proportion of our NHS will in fact be in private hands. If we look across the world to the US, Germany and other countries, we find that privatised health services do not support mental health to the degree that we in the NHS have supported it in the past. That is the most fundamental argument in my view. We have to protect our mental health services, albeit that they have been a Cinderella relative to the acute sector, but not to the degree that mental health services are Cinderellas in other countries where private health dominates.

That is my most important point. The only other part of the context is that the Bill will do nothing to make the changes that we need in the NHS, such as closures of redundant acute hospitals and redundant acute departments. I hope that this Government, unlike many previous Governments of whatever hue, will take the leadership role and show that they support mental health. I appeal to the Minister not to say that this is unnecessary. I appeal to him to agree that it is necessary and to give and show the Government's commitment to equality of parity of mental health and physical health in this country.

Baroness Williams of Crosby: My Lords, my noble friend Lord Alderdice made the strong point that in the real world mental health is not regarded as being on all fours with physical health. For the reasons presented by my noble friend Lord Carlile and others, clearly in the real world mental health is often hidden. It is often an issue that people do not freely address and it is vital that we send a clear signal from this House that mental health is absolutely equivalent in significance and importance to physical health, and that we believe that.

I shall briefly say what has already been said. Will the Minister at the very least consider taking this debate back and looking at whether there could be an agreed amendment that would meet his difficulties? There may be drafting difficulties, but it would not in any way resile from the statement that this House believes that mental health is vital and we want it on the face of the Bill. I plead with him to consider doing that.

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Lord Ribeiro: My Lords, I follow the noble Baroness in saying that I am speaking not because I see this as an amendment that should be pushed to a vote, but rather because I see it as a probing amendment that would allow the Government and the Minister to listen to the arguments being put today.

The whole thrust of the reforms is to provide care right across the community-secondary care, primary care and, let us not forget, social care. The mental health institutions started to be closed some 30-odd years ago, and care moved into the community. The ability to identify, diagnose and treat patients admitted into accident and emergency departments, often with psychotic diseases, is a major challenge. It certainly is for surgeons-for me in particular. As more psychiatrists are diverted to care in the community, the diagnosis and treatment of patients who appear in A&E departments is a challenge. It is quite difficult for those of us who have not had psychiatric experience. I was very fortunate that my house officer rotated through a psychiatric firm, so I had the benefit of somebody who was able to identify patients with psychotic illnesses and could advise me how best to deal with them.

It is important to identify the difference between physical and mental illnesses. I feel that this amendment would make a difference by clearly stating that there is physical illness

and mental illness in this section. I very much hope that the Minister will listen to the strength of the debate and come back with some answers.

Baroness Finlay of Llandaff: My Lords, I hope that the Minister will be able to break away from his brief and accept this amendment, because it is critical. As my noble friend Lord Walton has pointed out, the first part of the amendment talks about physical and mental health, but the second part implies that prevention, diagnosis and treatment are of illness, and there is a real danger of reading that as physical illness. The most tragic situation is where physical illness is misdiagnosed as mental illness or mental illness is misdiagnosed as physical illness. The consequences of that for patients can be disastrous.

In primary care, patients present with a completely undifferentiated picture. The general practitioner has to start from scratch, sort out the different parts and then refer to or consult other parts of the service, as appropriate, if he needs to. My noble friend Lady Meacher suggested that those services are in imbalance, and I agree with her that there is a danger when funding is short that you will lose the mental health component of services and that the culture change that this Bill is meant to bring about will not happen. A culture change is needed. Stigmatising labels have been attached to people with mental illness for many years. People with learning difficulties do particularly poorly in services overall. If we are going to take the opportunities of this Bill, we have one with this amendment: to flag up that there are mental and physical components to illness that need and deserve accurate diagnosis, the one as much as the other, that they are interrelated, that one affects the other and that we cannot provide a comprehensive health service without due regard to the totality-to the holistic person who is the patient in front of us.

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The Countess of Mar: My Lords, I too support this amendment very strongly, and I think the Minister knows why.

In my dealings with people with ME/CFS, I have found that many of them have been sectioned and put into wards that I can only describe as barbaric. There was one recent case where the man had a very clear physical illness and he spent nearly nine months in a hospital in Torbay-Torbay, the hospital that has been praised left, right and centre; but

its mental ward is not worthy of praise. If the funding is equal for mental and physical treatment, this will somehow redress the balance.

My mother was mentally ill for 17 years and she was treated barbarically by psychiatrists. She was hooked on barbiturates and she was given a leucotomy. I thought those days had gone but we are not far from them with the things that I have seen with ME patients.

Lord Eden of Winton: My Lords, we have listened to many powerful and persuasive speeches. I am tempted to go all the way with those who have advocated the inclusion of this amendment in the Bill, but I take up the words of the noble Baroness, Lady Finlay, who referred to the need for a cultural change. I think all noble Lords would agree that there is the need for a cultural change. I only question whether it is right to try to achieve that change through legislation. Surely what we are seeking to do is to change attitudes and get people to understand that there is no difference between physical and mental illness. For that reason, I think we need to hesitate before including words in legislation. What we need to do is to make people throughout the health service and everyone associated with the administration aware of the fact that there is no difference between physical and mental illness, and that those with mental illness need to be treated on an absolutely level footing with those with physical illness.

Baroness Thornton: My Lords, we on these Benches liked this amendment the first time round and we have not changed our minds. It may be symbolic in its effect-in fact, we think it all the better for that. Legislation should be the expression of policy and this amendment flows from important policy commitments by successive Governments about the parity of policy-making at all levels of the system to consider mental health alongside physical health. We give our very full support to the mover of this amendment and we urge the Minister to accept it.

I have two other remarks to make. First, I always listen extremely carefully to the noble and learned Lord, Lord Mackay of Clashfern. Frankly, if he says it is good enough for this Bill, that is good enough for me. Secondly, I agree with the noble Lord, Lord Newton, that it is a no-brainer. To the noble Lords, Lord Ribeiro and Lord Alderdice, and the noble Baroness, Lady Williams, I say that we are on Report. This is not the time for probing amendments. This is the time for taking decisions about what we want in the Bill. The Minister had the opportunity to take this away and consider it after Committee, when the House was as united in its view about this matter as it is today. Today I urge the Minister to accept this amendment but, if he will not, the House needs to express its view about this matter if at all possible.

Earl Howe: My Lords, we have had an excellent debate to mark the start of Report and I am very pleased-and, I must say, unsurprised-that the spirit of our debates in Committee has continued. I am particularly pleased that we have started with a topic as important as the parity of esteem between mental and physical health.

Amendment 1, moved by the noble Lord, Lord Patel, would ensure that the reference to "illness" in the description of the comprehensive health service refers to mental as well as physical illness. I am grateful to all noble Lords for the powerful case they have made for this amendment. I very much understand why this issue is of such importance to noble Lords, and why they believe that there is a declaratory value in inserting these additional words at this point in the Bill. As the noble Lord, Lord Patel, will be aware from our recent mental health strategy, achieving parity of esteem for mental illness is a priority for the Government. Therefore, I do not dissent in the slightest from the central principle being argued for here.

The question I have asked myself since Committee is whether the addition of these words would achieve what noble Lords intend, and whether they would add real value. In a strictly legal sense, they will not add value because legislation already makes it clear, through the definition in Section 275 of the National Health Service Act, that any reference to illness in the Act shall include both mental and physical illness. Therefore, wherever in the Bill the word "illness" appears, it already refers to both mental and physical illness. However, as my noble friends Lord Eden and Lord Alderdice said, what is required here-what really matters-are not words but concrete actions that will result in changes in attitudes and behaviours.

Before I tell the House which way I am leaning on the amendment, I will set out the steps that the Government have taken to that end. First, we are using the Bill to enhance the role of the NHS constitution. This plays an important role in emphasising the prominence and importance of mental health. It already contains a strong opening statement about mental and physical health. It declares that the NHS is there,

> "to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives".

Current legislation requires all NHS bodies and providers to the NHS to have regard to the constitution. The Bill creates new duties on the NHS Commissioning Board and clinical commissioning groups not just to have regard to it but to promote it. This is why we feel that NHS bodies, staff, patients and the public will in future be much more aware of, and hence responsive to, the NHS constitution and the parity of esteem that it champions. Therefore, I am afraid that I cannot agree with noble Lords who implied that the Bill is silent on parity of esteem. We are giving greater prominence to the NHS constitution precisely because we want to see greater awareness of the values, including parity of esteem, that it contains.

Secondly, we have used a range of operational levers to drive forward the importance of improving mental health. Mental health is featured prominently in the NHS operating framework. We have updated

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the NHS outcomes framework to include indicators for mental health outcomes in a holistic context. The public health outcomes framework has a set of key mental health and well-being outcomes identified for national and local action.

Thirdly, our mental health outcomes strategy makes it crystal clear that mental health services should have parity of esteem. We said in the document that it is our ambitious aim to mainstream mental health in England. Furthermore, as noble Lords know, we titled the strategy, No Health Without Mental Health. I can tell the noble Lord, Lord Patel, that we are going further still by looking to publish a full implementation framework for the strategy in April this year. This will be co-produced and jointly owned by national mental health organisations in partnership with government. Work is under way to develop the content of the framework, including consultation with a wide range of partners. My conclusion is that much work is afoot, as well as levers already in the Bill, to deliver the parity of esteem between mental and physical health that we all want to see in clinical practice.

I turn to the amendment. Should the noble Lord, Lord Patel, invite the House to add these words to the Bill? I am afraid that I have concluded that the noble Lord should resist the temptation. Having reflected very hard on these words, I believe that they could be positively unhelpful to his case, as well as to the business in which we are jointly engaged, which is the drafting of clear, economical and unambiguous legislation. "Illness" is already defined in the Act and, for me, these words are not only legally superfluous, they also suggest that there is a divide between mental and physical illness rather than a convergence.

4.30 pm

The noble Lord may believe that little harm would be done by his amendment, but I respectfully suggest to him that that may not be so. However, while I would urge him to withdraw it, I can tell the House that I am going to break away from my brief because my feeling has changed over the course of this debate. I agree that, given the nature of the Bill and the amount of time and discussion the House has dedicated to it, we could do more about the terms it uses, especially at the very start. In the light of that, and in response to the arguments made today, I would like to commit to undertake to do some further work to make clear the Government's commitment to parity of esteem. The first thought I have had-and I do not dare look behind me to my left-is that there is potentially an important role for the Explanatory Notes to the Bill. I can confirm, because I shall see to it myself, that we will be revisiting the Explanatory Notes to make it clearer that, with respect to Clause 1, "illness" refers to both mental and physical health. That is a very easy thing to do.

Secondly, I would like to invite the noble Lord, Lord Patel, and possibly other noble Lords, including my noble and learned friend Lord Mackay of Clashfern, if he is available, to have further conversations with me and with my ministerial colleague Paul Burstow to consider if there is anything further we could do, whether in the Bill or outside it, to promote parity of

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esteem between mental and physical health. I realise that I have not been able to meet the noble Lord on precisely the same territory as he has proposed, but I hope nevertheless that with the reassurances I have given, he will on balance be able to withdraw his amendment.

Lord Newton of Braintree: My Lords, perhaps I may say that if it was me who my noble friend was referring to as being on his left, I am thrilled to bits by his rather more constructive response. I congratulate him.

Lord Patel: My Lords, I wish that I did not need to speak at this point because I am really quite torn. I know how sincerely all those who have spoken feel about this amendment, and about emphasising the need to promote mental illness as having the same parity as physical illness. At the same time, I know how sincere the noble Earl is, and therefore it is difficult not to accept what he has said and the promises he has made. None the less, the comment made by my noble friend Lord Walton is the one that has affected me most: what is the key objection to putting these two words at the

front of the Bill to signify that mental illness is as important in its management as physical illness?

In my professional life I have dealt with physical illness, but I was always deeply affected whenever I had a patient suffering from postpartum depression or antenatal anxieties and sometimes psychosis; they were the most difficult to deal with. I would then have to seek the assistance of my psychiatrist colleagues.

Lord Elton: The noble Lord said that his noble friend was awaiting an answer to his question as to what was the objection? I have understood my noble friend to say that the objection was that it could actually make things more difficult because it would imply that there is a distinction between the two forms of medical treatment, which is exactly what we wish to negate.

Lord Patel: I did hear what the noble Earl said and I cannot say that I can accept that it would create difficulties if we included mental illness with physical illness. I do this with a very heavy heart, but I know that if I do not push the amendment, others will do so. On that basis, I think we should resolve the issue by seeking to test the opinion of the House.

4.34 pm

Division on Amendment 1

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Amendment 1 agreed.

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4.50 pm

Amendment 2

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

2: Clause 1, page 2, line 6, at end insert ", and

"(c) in the education and training of health care professionals"

Baroness Finlay of Llandaff: My Lords, this group of amendments addresses education and training as part of a comprehensive health service. The Government have given the Secretary of State,

> "a duty as to education and training"

that is now Clause 6. This is a welcome amendment to the Bill that we originally saw, and I warmly welcome the Government's amendments, particularly Amendments 61 and 104, which will embed a duty to promote education and training in the core duties of the board and the clinical commissioning groups.

My Amendments 63 and 105 are very similar. They specify that all providers, whether NHS or private, must train clinical staff adequately. They seek to ensure that private providers of services for NHS patients cannot undercut NHS providers by failing to

provide adequate training for their staff. All providers should ensure that clinical and other skills are kept up to current standards and that future generations of clinicians are also trained. I therefore hope that the Minister will be able to provide assurances that that will be spelt out in regulation, if it is not already clear. I expect that he may say that the Government's amendments cover the points of my amendments as they refer specifically to Clause 6 and its comprehensive scope. If I am right, it would seem that my amendments are not needed, as the point is covered-but, as I said, I would appreciate clarification. I hope, too, that the Minister can confirm that training must involve staff at every level, whether professionally qualified or not.

Let me turn to the lead amendment in this group, designed to place a duty on the Secretary of State to secure improvement,

> "in the education and training of health care professionals".

There are currently almost 1.2 million staff in the NHS, of whom 52 per cent are professionally qualified. We have been told, in debating this Bill, that the intention is for professional leadership in the NHS. These 600,000-plus staff must be able to take on that responsibility. Let me explain why this strategic overview and responsibility is needed at Secretary of State level. The rationale behind the Bill, we have been told, is to drive up quality and put patients at the heart of the NHS. There is a need for all healthcare services to be learning organisations, constantly reflecting through audit on whether they are reaching the required standards,

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ensuring that their staff are up to date with technical and scientific aspects of care delivery, and having a constant drive to having good attitudes and a culture of responsibility and care for those who are vulnerable-the patients and their families. These are fundamental to the ability to deliver a comprehensive health service.

Clause 1 has the Secretary of State's duty to,

> "continue the promotion in England of a comprehensive health service designed to secure improvement ... in the physical and mental health of the people of England",

and now,

> "in the prevention, diagnosis and treatment of",

physical and mental illness. It is impossible to achieve these without securing ongoing improvements through the education and training of all professionals. In his letter of 12 January, the Minister wrote outlining four key elements of the new system proposed for education and training, covering the plans for Health Education England, local education and training boards, the transparent funding of the system and transitional arrangements. We will debate these later in detail, and this amendment in no way detracts from the amendment tabled by my noble friend Lord Patel, which is coming up later on in proceedings. All those amendments are compatible with putting the education and training of health professionals at the very top of the Bill, in Clause 1, as they are part of the comprehensive package that the NHS uses to deliver the best care to patients.

There are almost 98,000 medical and dental staff in the NHS. Medicine and medical care is underpinned by science. Medicine bridges the gap between science and society. This science is constantly evolving; its appropriate application to human health is a crucial aspect of clinical practice and care to achieve better outcomes for patients. Medicine is distinguished by the need for judgment in the face of uncertainty. Much of medicine's unpredictability calls for wisdom as well as technical ability. Everything flows from accurate diagnosis. A commitment to quality improvement allows crucial skills to be passed on to the next generation.

We have heard much about the merits of competition. Doctors and those in many other disciplines in healthcare are almost inherently competitive, and they generally want to be providing high quality service with better outcomes and to be rated highly by their colleagues. That is the competitive spirit that the Government should be able to exploit to drive up standards. Good attitudes are bred from good role models.

There are core values, behaviours and relationships that underpin professionalism in relationships with each patient, and these were exposed in the report by the noble Baroness, Lady Cumberlege, *Doctors in Society*, on behalf of the Royal College of Physicians. The attitudes and values that healthcare professionals must be committed to in their day-to-day practice involve integrity; compassion; altruism; continuous improvement, which means always learning; a desire for excellence; and an ability to work in partnership with others in the wider healthcare and social care team.

Patients certainly understand the meaning of poor professionalism and associate it with poor care. The public are well aware that an absence of professionalism is harmful to their interests. There have been too many reports into inadequate care in recent years. They

repeatedly catalogue a lack of standards and poor quality processes and repeatedly recommend education and training of staff at all levels. The NCEPOD report, *Emergency Admissions: A Journey in the Right Direction?*, said that trainee doctors,

> "need to have adequate training and experience to recognise critically ill patients and make clinical decisions. This is an issue not only of medical education but also of ensuring an appropriate balance between a training and service role; exposing trainees to real acute clinical problems with appropriate mid-level and senior support for their decision making".

The Healthcare Commission report into the substandard care in Mid Staffs states on page 45:

"From April 2008, there was only one permanent consultant, virtually no education and only limited supervision".

On page 46 it says:

"Senior members of the department said that there was a 'non-existent culture' with regards to education and training. Additionally, several interviewees specifically mentioned that three-quarters of dedicated teaching sessions for junior doctors were cancelled, usually by managers on operational grounds".

There is a virtuous spiral of education, integration and quality improvement. Learning across professional boundaries has been shown to foster integration as healthcare professionals understand better what others can offer in care, thereby driving up quality. They also learn the limits of their own experience and different ways of doing things, to the benefit of all.

If we are to have a constantly improving NHS, education and training must be at its heart. If we are to expect GPs to commission properly, they will need training to recognise poor commissioning advice. If we expect better care from the staff, we must ensure that they are in a system that is driven constantly to improve. I beg to move.

5 pm

Lord Turnberg: My Lords, I put my name to Amendment 12 but I have shifted my allegiance to Amendment 13, along with other noble Lords. However, I want to speak to the other amendments in my name in this group. In doing so, can I say how much I, too, very much appreciate the government amendments in this group?

At the end of the day, education and training have to be provided within hospital trusts, in general practice and-a slightly separate issue-in local authorities for public health consultants. At this level, local education and training boards are to be given responsibility for overseeing the provision of all this education. Here, local employers are to play a key role in the trusts. These local employers clearly have an interest in being able to plan for their manpower needs and in having an influence on what sort of training their employees should have to do the job that they want doing. However, they are not in the best position to decide the educational content of the programmes that the trainees go through. They are not best able to design the training or education of an orthopaedic surgeon or cardiologist, for example.

Furthermore, they may have a conflict of interest when they are asked to make sure that the facilities for training are adequate to their trusts' needs. Is there a full range of patients coming through the hospital to give trainees the necessary experience so that a specialist

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trained in one area can practise somewhere else? Are there enough staff to enable trainees to have the time they need for education? Will they have the time to attend courses? Will it be in the trusts' best interests to allow the rotation of their trainees to other trusts? In all these areas employers may have different priorities. For this reason, it is vital that we have the input of those with particular expertise in and knowledge of education and training, and enough independence to ensure that the training needs of the trainee are met.

Hitherto, specialist postgraduate training has involved the medical royal colleges in designing the curricula and educational programmes for trainees, and in setting and running the postgraduate exams and assessments, while the postgraduate deans are responsible for ensuring that local conditions are right for trainees-that training posts are available and for funding those posts. With the dissolution of the strategic health authorities, the postgraduate deans and deaneries are left in the air and the local education and training boards are to be taken over by the employing authorities. The amendments in my name try to redress that balance by ensuring that the training boards have in their membership the independent voices of those-namely the universities-whose prime role is to help them with the activities. To this I would add the postgraduate deans and colleges. Furthermore, it is important that the local education and training boards, while quite reasonably including local employers, should not be led by them. Boards should have sufficient independence to keep employing authorities focused on meeting the needs of trainees. That is why I have tabled these amendments.

I know that the Minister has given some reassurance from the Government along those lines in the letter that he has written to some us. He said in his letter, which I hope he will not mind my quoting back to him:

"This framework will be maintained in the new system, with the LETBs assuming responsibility for the quality management role at local level".

That bothers me a little. Quality management should be independent of the employers themselves. We now need to see something in the Bill that will give us the confidence that it will happen.

My name is also attached to Amendment 105. Here we are concerned specifically that private providers should not be able to shirk their responsibility for training. There is no doubt that training requires more time and money. If private sector providers are able to avoid training, they will have an unfair advantage over NHS providers. Of course, there is much valuable experience and training to be gained from private practice. For those reasons, I am happy to support this amendment, too.

Lord Willis of Knaresborough: My Lords, I support government Amendments 61 and 104. As regards Amendment 2, which the noble Baroness has introduced, Clause 6 adequately describes the duties of the Secretary of State in relation to education and training. My noble friend the Minister has done an incredibly important job in recognising the real anxiety that existed at Second Reading about education and training. Indeed,

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we are grateful to the noble Lord, Lord Walton, for withdrawing his amendment at that time as that has enabled major discussions to take place on the issue.

Government Amendments 61 and 104 bring us to the heart of who will be driving much of the education and training-that is, the national Commissioning Board and the local commissioning groups. In fact, neither of these groups seems to have any responsibility for education and training, even though, as the noble Lord, Lord Turnberg, rightly says, they will be right at the heart of commissioning the healthcare required, whether it is in an NHS setting or a private, approved setting. That appears to be an omission in the Bill.

Although I have much sympathy with Amendment 109 of the noble Lord, Lord Turnberg, and he is right to point out that there is a requirement on private sector providers or, indeed, third sector providers, to engage in training, I hope that when the Minister winds up on this group of amendments he will point out the advantages to those

providers of engaging in education and training. Indeed, he has privately assured many of us that they are more than willing to do so because they cannot become qualified providers unless they are engaged in cutting-edge training and education.

In Amendment 109, the noble Lord, Lord Turnberg, raised the important issue of the involvement of universities. It worries many of us that the universities which have been very much at the heart of education and training, particularly postgraduate education and training, appear to be sidelined in the new architecture of the Bill. Frankly, that is unacceptable. It should not be for local employers to decide whether or not they want a university to be involved; it should be a requirement for universities to be involved. We must not have a situation where universities are regarded as predators in relation to education and training, as they are fundamental to it. If research is a fundamental part of the architecture of the Bill and of improving patient care, frankly, it is absurd to have universities outside that remit. Therefore, I hope that when the Minister responds he will assure us that universities are part of the solution-as the noble Lord, Lord Turnberg, rightly said-and are not seen as part of the problem.

Lord Walton of Detchant: My Lords, I have just counted that in the course of the past few weeks and months I have attended 28 seminars, group discussions and personal meetings with Ministers, the Bill team and others. That was extremely useful. We have spent a lot of time discussing education and training. I pay warm tribute to the Minister-the noble Earl, Lord Howe-and his team and colleagues for the way in which they have responded and listened to many of the concerns which we have expressed about these problems. The Government have tabled a number of very helpful and constructive amendments. However, I seek to ascertain whether they meet all our concerns.

I know that the noble Lord, Lord Willis, will say that our earlier concerns about research and its role in the NHS have been completely met. I agree with him entirely. We are satisfied on that point. However, in relation to education and training, I said at Second Reading that since the health service began, undergraduate training of doctors, medical students and dental students

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had always been the financial responsibility of the universities, but that it had always been the responsibility of the NHS to provide the clinical facilities in hospitals and general practices of the United Kingdom for the training of those undergraduate students. Of course, in more recent years, the newer universities-the former polytechnics-have played a major role in the training of other healthcare professionals

such as nurses, physiotherapists, occupational therapists, speech and language therapists and others. That commitment has been totally accepted.

However, postgraduate training of doctors, as the noble Lords, Lord Turnberg and Lord Willis, have said-those who are training to become physicians, surgeons, psychiatrists, and specialists in any branch of medicine-is the financial responsibility of the National Health Service and has been from the very beginning of the NHS. At the same time, the NHS has employed postgraduate deans who have been very helpful and responsible in helping to provide that training. It has also been monitored throughout by the royal colleges and faculties that have provided the content and curricula for the training of these groups of specialists. It is crucial that that interrelationship of all these bodies be enshrined in the Bill, even when Health Education England comes into being. I am mildly surprised that all the amendments grouped with Amendment 2 deal with education and training, but so too do Amendments 13, 16, 62 and 106 that are equally important and crucial to this whole programme.

I therefore ask the Minister whether he is satisfied that in the amendments that the Government have tabled, or in regulations that he can assure us will follow, the responsibilities of the universities and other institutions of higher education will be enshrined and clarified. Is he satisfied that through the postgraduate deans and the clinical senates-wherever they are housed, or whether they are housed with the National Commissioning Board and its outreach into parts of the country-the responsibilities of the royal colleges and faculties will also be enshrined, and the postgraduate deans will thereby continue to supervise the programmes? Is he satisfied-and this is crucial-that independent foundation trusts and any qualified providers that are providing NHS services will be required to accept responsibilities for the training and education of healthcare professionals, just as NHS hospitals, general practices and other NHS institutions are?

It is crucial that these issues are confirmed, and I trust that the noble Earl will be able to tell us that in the government amendments, and in regulations that may follow, all our anxieties about these major issues will be accepted and covered to the benefit of the healthcare workforce and the National Health Service overall.

The Earl of Listowel: My Lords, I rise briefly to pay tribute to the noble Earl, Lord Howe, and his colleagues for giving this most important issue such great attention since the Bill arrived in this House.

I wish to look at the experience in social work, where there has been great deterioration in the attention given to the professional development of social workers. I remember reading a letter from the noble Lord, Lord Hunt, when he sat on the Front Bench a few

years ago,

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acknowledging the fact that newly qualified social workers were being placed in situations where they had too large a case load and were not being properly supervised. Fortunately, some steps have been taken to address this, but there is clearly still a long way to go on supervision of social workers, and the culture and state of morale of social workers has for many years been eroded by the lack of attention to their professional development. There was a time when there was good professional development; so it can happen, and it could happen in the medical professions.

Perhaps I may draw attention to the experience of teachers in Finland. This is particularly relevant to the Minister's and the Government's desire to increase autonomy within the health service and devolve responsibility down to the professionals closest to the front line. About 20 years ago, Finland reviewed its education system and decided to emphasise the professional development of its teachers. It decided to select its teachers very carefully, and now all practising teachers have a masters qualification before practising with children. Only one out of 10 applicants for teacher training places is accepted: there is huge competition to get on those courses. A few years ago, when PISA started publishing league tables of education system performance across the world, the Finns came out top of the numeracy, literacy and science tables, not just in one year but in successive years. Teachers are given a huge amount of respect within their society, very good professional training and development, and are well recruited. There is no inspection of the education system-teachers are so well trusted to do the best for children.

I pay tribute to the noble Earl and colleagues for giving this the best possible attention in the course of proceedings in your Lordships' House.

5.15 pm

Lord Patel: My Lords, I pay tribute to the noble Earl for how he has met our concerns in the Committee debate on education and training. The noble Lord, Lord Walton, mentioned Amendments 13 and 16. To me, Amendment 13 is crucial. The reason I degrouped them is because Clause 6 addresses the Secretary of State's responsibility for education and training. I hope that we will have the debate about the issues that he raises when we debate Amendment 13. I agree with the amendment of the noble Lord, Lord Turnberg-Amendment 16-which provides that universities need to take a greater part in education and training than they have hitherto.

Lord Hunt of Kings Heath: My Lords, as this is a new stage of the Bill, I should declare a number of interests which are also listed in the register; I am chairman of the Heart of England NHS Foundation Trust, a consultant and trainer with Cumberlege Connections, president of the British Fluoridation Society and of the Royal Society for Public Health.

I put my name to Amendment 2, tabled by the noble Baroness, Lady Finlay, which has perhaps not received as much enthusiasm as I would have wished from noble Lords, who have pointed to Clause 6. Behind her amendment is real concern to ensure that

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we will train enough health professionals in the years ahead and that they will be of sufficiently high quality. There is some history here. I very much support devolving as much as possible decisions about the commissioning of training places to local NHS organisations. I warmly welcome the work of Dame Julie Moore and her team, who have produced the report. She is chief executive of the UHB Foundation Trust in Birmingham and brings a lot of expertise to that position. Some noble Lords will have been to a seminar where the report was debated. I have no argument with its general thrust, but we know from experience that when money is tight, the NHS reduces the number of people that it trains and its training budget. That always happens and, a number of years later, the NHS then pays the consequences. If we are to have a highly effective National Health Service in future, we need to recognise that the quality of our professional staff goes to the core of what we seek to do. Therefore, it is right that the Secretary of State should be seen to have major responsibilities enshrined in legislation. That is the essential point of Amendment 2, whatever the technical deficiencies to which noble Lords have kindly drawn our attention.

In that regard, let me say that I welcome the government amendments in this area and the work of the noble Earl, Lord Howe. Of course, he is also responsible for research in the department, and I think that he well understands how the education and training of our professionals very much ties in to the research agenda. I know that we will come to research later tonight.

In relation to the other amendments in this group, I have already welcomed the government amendments, but perhaps I may pick on Amendment 63. It is right that the national Commissioning Board should have regard to the promotion of training of clinical staff in any provider from which it commissions services. There is essentially a parallel amendment-Amendment 104-which applies to clinical commissioning groups. The whole point here is to ensure that there is a level playing field. If, regrettably, the Government persist with this lunatic idea of a competitive approach within the health

service, it is essential that when it comes to commissioning decisions all qualified providers contribute to education and training. It would be an absolute disgrace if clinical commissioning groups and the national Commissioning Board started to commission services from organisations that did not play their full part in education and indeed research. I hope that the noble Earl, Lord Howe, will make it clear that that is what his Amendment 104 means when it says, in parliamentary counsel terminology, that clinical commissioning groups must,

"have regard to the need to promote education and training".

I take that to mean that the amendment does not permit CCGs to place contracts with qualified providers who do not make a contribution to education and training.

Overall, I echo the words of the noble Lord, Lord Walton, regarding the work of postgraduate deans and his question about their future. Where are postgraduate deans going to lie in the future? Are they going to lie in the local branch offices of the national

Commissioning Board; are they going to be aligned with the clinical senates; or are they going to float free? I think we should be told.

I also echo the words of the noble Lord, Lord Willis, regarding the role of universities. It should not be an option; they need to be round the table. It needs to be what I would describe as a "hard partnership". I think we are all well aware of the issues and concerns surrounding the quality and outcome of nurse training. The noble Earl, Lord Howe, himself has often commented on issues such as dignity, nutrition and so on, where matters have been raised by patients and there is concern about whether today's nurses are getting the kind of training that is required. It is very important that those who commission from universities do so in as vigorous a way as possible and hold those universities to account. However, equally there has to be a partnership. The noble Earl, Lord Howe, will know about the intention to expand academic clinical science networks. That is a very good example of universities and the health service coming together, and we need to encourage that in the future.

Finally, the noble Lord, Lord Walton, raised a point about the duty on any willing provider regarding training or research. I think that I have covered that, but he also mentioned NHS foundation trusts. I am not aware of any situation in which NHS foundation trusts are ignoring their responsibilities but I certainly agree with him that, as they are more independent of the Secretary of State than other parts of the NHS, some assurances from the noble Earl in that regard would be welcome.

Lord Northbourne: I wonder whether the noble Lord could clarify a point for me. In his Amendment 62 he speaks of the "healthcare workforce", whereas the noble Baroness, Lady Finlay, in her amendment talks of "healthcare professionals". Are these identical groups of people? I am particularly interested in whether nursing staff are included in one or both of those terms.

Lord Hunt of Kings Heath: My Lords, that is a very good point. As I say, it is always helpful when noble Lords point out errors and omissions in the drafting of amendments. Amendment 2 refers to "health care professionals", and I am clear that nurses must be embraced within that definition.

On Amendment 62, I would not detract from the use of,

> "education and training of the healthcare workforce".

Earl Howe: We are not debating that amendment yet.

Lord Hunt of Kings Heath: My Lords, the noble Earl, Lord Howe, has kindly reminded me that we are not debating Amendment 62. It will be debated in a later group, which allows me a little time to reflect on the point raised.

Earl Howe: My Lords, this has been a very useful debate. Perhaps I can begin with a clear statement that the Government are committed to the education, training and continuing development of the healthcare workforce. This is fundamental in supporting the delivery of excellent healthcare services across the NHS. I am pleased that so many noble Lords share that view.

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We are, however, in the rather odd position of having before us two groups of amendments on education and training. Given that we still await a further debate on the subject today, I should like to reserve some of the detail of my remarks, if I may, for that debate, when I address one of the amendments in the name of the noble Lord, Lord Patel. However, to begin with, and for now, I think that it will be helpful if I set the scene.

First, I confirm to the noble Baroness, Lady Finlay, that we made clear in *Liberating the NHS: Developing the Healthcare Workforce-From Design to Delivery*,which was published

recently, that we are committed to a national framework for education and training, with Health Education England providing national leadership and being directly accountable to the Secretary of State.

Health Education England will ensure that the healthcare workforce has the right skills, behaviours and training, and is available in the right numbers to support the delivery of excellent healthcare and health improvement. It will work with a range of key partners, including the medical royal colleges, professional regulators and the academic and research sectors. The national input and oversight will be there in all the areas which, rightly, the noble Baroness is concerned about. Health Education England and the wider education and training system will, as I said, remain accountable to the Secretary of State, who will have a duty to secure an effective system for the planning and delivery of education and training in the NHS. Employers and healthcare professionals will play a leading role in workforce planning and development through the establishment of local education and training boards, working with the education and research sectors. I shall have more to say about that in a moment.

I can reassure noble Lords straight away that postgraduate deans will continue to be a critically important part of the medical training arrangements. The Government listened to the concerns expressed in Committee by a number of Peers that the Bill did not go far enough in safeguarding the future education and training system. In this group of amendments, which I shall speak to shortly, we have tabled a number of proposals designed to address the gaps that noble Lords identified.

On Amendment 2, tabled by the noble Baroness, Lady Finlay, the Government have already introduced a duty for the Secretary of State to maintain an effective system for education and training. Our duty is more comprehensive than this amendment in that it applies to the whole healthcare workforce and not just doctors. The noble Baroness asked about the scope of Clause 6. Our duty applies to people who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England. This covers healthcare professionals at the centre of delivering healthcare, including doctors, dentists, nurses, midwives, pharmacists, healthcare scientists and the allied health professions. It includes registered and unregistered professions. It also covers non-clinical staff who are involved in, for example, the commissioning or administration of services. In the

light of that, I hope that the noble Baroness will feel reassured to some extent and feel able to withdraw her amendment.

5.30 pm

The noble Lord, Lord Walton, put particular emphasis on the universities being involved in local education and training boards. We wholeheartedly agree that it is crucial that universities and other education providers are integral partners in the planning, commissioning and delivery of education. Health Education England will set robust criteria for the establishment of the local boards, and strong and meaningful partnerships with universities will be a key element of that assessment. The core purpose of the local boards is to lead planning and education commissioning to ensure security of supply of the local health and care workforce and to support national workforce priorities set by Health Education England. They will have a number of functions which I have detailed in a recent letter to noble Lords. One of them will be to hold and allocate funding for education and training. Others will be to commission education and training, to secure quality and value from education and training providers and to secure the partnerships that we want to see with clinicians, CCGs, local authorities, health and well-being boards, universities and other providers of education, research and innovation. At the same time, however, Health Education England will be overseeing that, securing national coherence and greater transparency in the education and training investments that employers make in their workforce.

The noble Lord, Lord Turnberg, asked me about the role of the royal colleges and postgraduate deans. We have no intention of tampering with national standards. Professional regulators will continue to set professional standards. The royal colleges will continue to shape curricula and will work in partnership with Health Education England to ensure that education and training reflect best practice and are of high quality. Professional regulators have a statutory responsibility for setting standards and ensuring those standards are met and maintained. The new system goes further because we have developed quality indicators that will bring quality to the heart of the commissioning process. The education outcomes framework, which I will say a bit more about when I come to address the later amendments tabled by the noble Lord, Lord Patel, will set out the outcomes expected to achieve quality healthcare, education and training. Indeed, one of Health Education England's key functions is to promote high-quality education and training that is responsive to the changing needs of patients and local communities.

Let me say a little more in answer to the noble Lord, Lord Walton, about postgraduate deans. Postgraduate deans will remain critical to these training arrangements. We expect local education and training boards to be able to demonstrate that their

postgraduate deans will be able to act independently of any perceived conflict of interest that may arise between training and service priorities. There will be clear checks and balances in place and quality metrics to hold local education providers to account for the quality of the education that they deliver. Postgraduate deans will

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have all the powers that they have now to respond to concerns about the quality of training, to take action where required to improve standards and to assure the professional regulators and Health Education England that poor performance, if it occurs, is identified and tackled. In the new system, they will have what I hope will be the welcome support of the local education and training board, and, if necessary, Health Education England, to challenge poor quality and behaviours. We believe that the checks and balances will be there in the system.

The noble Lords, Lord Walton of Detchant and Lord Hunt of Kings Heath, asked about the involvement of qualified providers other than NHS providers. All providers of NHS-funded services will be expected to participate in the planning and delivery of education and training. Health Education England will allocate funding for investment in the future workforce only to those that participate. We will be considering in future weeks what additional duties we might place on all providers when we look at proposals for a future Bill on education and training.

The noble Lord, Lord Hunt of Kings Heath, referred to funding. Many respondents to the consultation called for education and training funding to be protected. We agree, so we will ensure that Health Education England establishes transparent systems to make sure that organisations that receive MPET funding are held to account for using it for the education and training of the NHS workforce.

As I said, the Government have listened to the concerns expressed in Committee by a number of Peers. We have already introduced the duty on the Secretary of State to exercise his functions so as to secure an effective system for education and training. Amendment 15 puts more flesh on that duty by specifying the Acts that contain functions that must be exercised by the Secretary of State so as to discharge his education and training duty.

Building on that, we have tabled amendments to strengthen links with the wider system. Amendments 61 and 104 place duties on the board and on CCGs to have regard to the need to promote education and training. These duties are designed to ensure that commissioners of NHS services consider the planning, commissioning and delivery of education and training when carrying out their functions.

Nationally, Health Education England will work with the NHS Commissioning Board to ensure that its strategic framework for education, training and workforce planning reflects service commissioning priorities and that workforce development implications of innovation and changes in the pattern and nature of services are addressed and identified. As I indicated earlier, CCGs will work with the local education and training boards to consider the workforce implications of their local service commissioning decisions.

The other amendments tabled in this group by noble Lords are, I believe, designed to have much the same effect. I hope that noble Lords will be reassured by the vision I have set out for education and training and by the amendments that we are proposing, and

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that they will feel able to support those amendments in due course when they are moved and, for now, to withdraw theirs.

Baroness Finlay of Llandaff: I am most grateful to the Minister for the amendments that he has tabled on behalf of the Government, and for all the listening. This short debate has demonstrated just how far we have moved, how much he personally has taken on board and committed to improving education and training, and that the amendments that are there for us to approve later provide a scaffolding throughout the Bill for education and training that was not there before. I fully accept that the amendment in my name is probably in the wrong place in the Bill and that to restrict it to professionals is too narrow-it is the whole workforce. Therefore, I beg leave to withdraw the amendment.

Amendment 2 withdrawn.

Amendment 3

Moved by ***Baroness Thornton***

3: Clause 1, page 2, leave out lines 7 to 9 and insert-

"(2) The Secretary of State must for that purpose provide or secure the provision of services according to this Act."

Baroness Thornton: My Lords, we originally put down Amendments 3 and 4 in Committee back in the autumn. It has to be said from the outset that this is actually still

a very bad Bill. Since Committee, the context in which we are discussing this Bill has without doubt changed. It seems that it has no support from anywhere except in the Department of Health-and possibly not even from everybody there. It still has no mandate.

Going back on previous commitments to,

> "no more top-down reorganisation of the NHS",

the Prime Minister and his Health Ministers, including the noble Earl, have adopted what we on these Benches would like to term the "Attlee defence", in deference to the noble Earl, Lord Attlee-and I mean the Government's Earl Attlee, not ours, as it were. Last March, during a debate on the Building Regulations (Review) Bill, in trying to explain the Government's position, the noble Earl came up with:

"I gently remind the Committee that I answer for Her Majesty's Government, not for the previous Opposition".-[*Official Report*, 4/3/11; col. 1352.]

That is a remarkable statement. Perhaps the Minister could gently remind the Prime Minister and the Health Secretary of their coalition agreement.

It is significant that the Prime Minister has had to come to the Bill's rescue today, not least because a Downing Street source yesterday was reported to threaten the very life of the Secretary of State-I think that the words used were "taken out and shot"-for his failure to communicate the Bill and the Bill's policy. We in the Opposition have never advocated such a thing. Perhaps the Minister would like to comment on this particular version of the Secretary of State's ultimate responsibility in his job.

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The Prime Minister's words were also revealing in that the Government intend to push this Bill through. I do not believe that that is a respectful way of referring to the remaining stages in your Lordships' House. It begs a question that I should like to ask the Minister early in Report stage, which arises from what happened recently as regards the Welfare Reform Bill. Will he give the House notice now as to whether the Government intend to use the financial privilege mechanism to strike down any amendments that this House might agree during the remaining stages of this Bill?

I have searched in vain for a precedent of legislation that is so unwelcomed by those who have to deliver it, so incomprehensible to those on whom its consequences will be wreaked and so difficult to explain in simple terms. But even the Minister, who is acknowledged by the whole House to be an outstanding performer and someone who can normally enlighten us about most matters in clear, plain English, has had to resort on many occasions to seeking to justify points of this Bill in the managerial jargon of his boss, Mr Lansley, which is as dense as the Bill itself. If any noble Lords doubt that, I suggest that they need only to peruse the record of the Committee stage.

We do not work in a sealed bubble in this Chamber and I appreciate that the Government might prefer it if that were the case. But the public's view of this Bill has shifted and hardened since we completed the Committee stage before Christmas. The views of those who have engaged with this Bill for more than a year have changed and we need to hear their voices throughout Report stage.

As we all know, the discussions around the role of the Secretary of State have been of great significance. What has emerged is that the reasons for changing the role have never been made clear. As has been pointed out, there is a continuity around the role of the Secretary of State which goes way back to the founding of the NHS. I will not rehearse all the arguments that we heard in Committee and at Second Reading, and which some of us have been rehearsing during the months between those stages and up to last week. The reality is and always has been that the legal duty on the Secretary of State is to provide services. Even securing the provision of services has been delegated to organisations which deliver that duty on behalf of the public. Public accountability is and always has been vital to maintaining public confidence in the NHS. Ultimate political accountability exists in the person of the Secretary of State.

In no way can the Secretary of State argue that any failure to provide necessary NHS services is not his or her responsibility. The argument that if there is an issue the Secretary of State must work through failure regimes, regulations and directions to others is not good enough. As the Health Select Committee and many noble Lords, including the noble Lord, Lord Mawhinney, said in Committee, it would not be believed anyway.

We will be moving to the alternative wording in the next debate. We on these Benches have supported the process that has led to that wording. However, I should like the Minister to explain-I would be very happy to hear that explanation when he responds to the next

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debate-the difference between these words and those that are before the House. I am giving the Minister notice that this remains a bit of a mystery.

As with so much else in this unloved Bill, we are left with the question: why? Why on earth did the original Bill propose a radical change to the role of the Secretary of State? The Minister in the Commons, Simon Burns, was ready to die in a ditch for the wording. It was a liberation ideology for him. Why, throughout the scrutiny in the Commons, was the line rigidly held by coalition Ministers and MPs, and why is the Secretary of State-I really do think the House needs to know the answer to this question, but again I am quite happy to wait-now briefing royal colleges saying, "Actually, the changes that noble Lords have agreed in their Chamber will make no difference to the Bill"?

Our amendment and the others that deal with the role of the Secretary of State are important and we have undoubtedly prised improvement out of, if not a reluctant noble Earl in this Chamber, certainly out of a reluctant Government. Many of these issues are proxy arguments about what kind of NHS we want. During the rest of the Report stage we will focus our energies on the many other things that need to be changed, particularly in Part 3. These are part of the argument about why we do not want a full market, why we do not want regulation along the lines of that for the utilities or for the banks, and why we need to protect and preserve the tradition, well established and well understood, of the role of the Secretary of State.

I will be withdrawing the amendment, as I promised the Minister I would, but I would like some answers to the questions that I have posed in these remarks. I beg to move.

5.45 pm

Baroness Williams of Crosby: My Lords, perhaps I may respond very briefly. The real argument that we should be having is almost certainly on the next group of amendments, and I have no intention of taking away from that debate in which, as we know, the noble Baronesses, Lady Jay and Lady Thornton, and other noble Lords-although unfortunately not my noble and learned friend Lord Mackay today-will take part. It is an important debate that symbolises for me something of crucial significance, and that is that in this House we have moved towards all-party agreement on the constitutional underpinning of the National Health Service; that is a great achievement.

I shall not take further from what the noble Baroness, Lady Jay, will want to say-except that perhaps I shall follow her on this issue-beyond saying that I am deeply saddened that over the past day or two we have seen what I believe to have been a far-reaching and radical attempt in this House to try to present an all-party consensual underpinning for the National Health Service being turned into what one can only describe as the

most petty of political rows whose seeming intention is to try to acquire political balance for one side or the other. That is a great shame.

I think that many of us believe that the wording which has been accomplished- although I note the commitment of the noble Baroness, Lady Thornton,

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to the word "provide"-means that we can be satisfied with the constitutional group. We do not need to change the wording and what is now set out in the Bill after this long exercise is in fact legally watertight. I say that because some of the most distinguished lawyers in this House were part of the drafting process, including on the Labour side the noble and learned Baroness, Lady Scotland. On the Conservative side we had the outstanding figure of the former Lord Chancellor, my noble and learned friend Lord Mackay of Clashfern, and on my side, among others, my noble friends Lord Clement-Jones and Lord Marks of Henley-on-Thames. All these lawyers put their heads together in order to establish a basis on which we could agree, and I would suggest to the noble Baroness, Lady Thornton, for whom I have a great deal of respect, that if the word "provide" did not surface during that exercise, it is because it is to a great extent at odds with the facts at the present time as to who actually provides services for the NHS, and of course that has changed radically in recent years. It has changed radically because of steps taken not only by the present Government but also by the previous Government, when a great deal of provision came from newly established elements in the private sector, including intermediate treatment centres. Efforts were made to bring about an extensive network of hospitals to look at how far private treatment could be accepted and it was done on the basis of trying to bring new providers on the scene, which the noble Lord, Lord Darzi, among others, has talked about. I am probably one of those who are more "old-fashioned" in their view of the privatisation of the NHS, which I certainly would not support. That is not the same as talking about the competitive providers who under the previous Government and the present one have made some contribution to the services of the NHS.

I say with great respect to the noble Baroness that this pair of amendments is unnecessary. I think that, legally, the existing wording now stands up and has the precious boon of having been supported by all parties in this House and those who sit on the independent Cross Benches. We should therefore move on to the next group of amendments and be able, among other things, to celebrate our achievement, which I hope will enable the National Health Service to flourish and survive into the rest of this century.

Earl Howe: My Lords, as my noble friend has correctly reminded us, the next debate will give us the opportunity to discuss the package of amendments designed to clarify the Secretary of State's accountability for the health service. I recently completed a series of meetings with Peers from across the House to understand their concerns about this and related issues. Thanks to the efforts of so many here today, including the noble Baroness, Lady Thornton, I am pleased to say that we have sufficient consensus to table a series of amendments on this matter. I very much look forward to discussing them when we reach subsequent groups.

Amendments 3 and 4, tabled by the noble Baroness, Lady Thornton, seek to reinstate the duty to provide. I do not wish to dwell too long on what I have said on previous occasions, but the noble Baroness will be

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aware that we are retaining the wording of the NHS Act 1946, where appropriate. For example, the Secretary of State retains his duty to,

> "continue the promotion in England of a comprehensive health service",

and his duty to,

> "secure that services are provided".

The reason for our removing the 1946 duty on the Secretary of State to provide services himself is that it fails to reflect the reality of the way that NHS services are delivered. In general and for many years, the Secretary of State has not himself exercised functions of providing or commissioning services. The functions are delegated to SHAs and PCTs. Under the Bill, however, this function will be conferred directly on a dedicated NHS Commissioning Board and CCGs.

Indeed, as my noble and learned friend Lord Mackay of Clashfern has pointed out previously, there has never been a straightforward duty to provide services. The requirement was framed as a duty to,

> "provide or secure the ... provision of",

services. In practice, Ministers or the NHS bodies responsible for exercising the Secretary of State's functions have usually exercised the second option, securing the provision, rather than the first, actually providing. The Secretary of State-that is, the Department of

Health-has not provided NHS services directly for many years. Our policy is that the Secretary of State should neither provide nor commission NHS services.

It is clear from these amendments that the Opposition are harking back to a centralist, top-down approach. They sometimes say that they want clinical commissioners, but these amendments contradict that. They would not create a system of clear responsibility but instead one where Richmond House was always right. That model has been tried to the point of exhaustion and has been found wanting. In contrast, the Bill establishes a framework in which the Secretary of State no longer has the powers to provide or commission NHS services. Instead, those functions are conferred on other bodies in the system. An amendment to Clause 1 to impose a duty on the Secretary of State to provide services-or a duty to exercise his functions so as to provide them-is simply not consistent with that framework.

When this issue has been debated previously, one of the main arguments against losing the duty to provide was that it would result in reduced accountability to Parliament for provision. Although that has never been our intention, we have, as I said, tabled amendments to put beyond doubt the matter of ministerial accountability. Given that the Secretary of State does not provide services directly, and that the amendments we will debate shortly clarify beyond doubt the Secretary of State's continued accountability to Parliament, it is not clear what an amendment to reinstate the duty to provide would achieve in practice.

If these amendments are about ensuring that the Secretary of State takes the steps required to secure the proper provision of NHS services, I simply reassure the noble Baroness that the Bill already does this. It requires the Secretary of State to,

> "exercise the functions conferred by this Act so as to secure that services are provided".

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That is a strong and onerous duty, sufficient to ensure that the Secretary of State discharges his responsibility for the NHS.

In explaining these amendments, the noble Baroness repeated her call for the Bill to be withdrawn on the grounds that nobody supports it. I acknowledge that there are opponents of the Bill but she must also acknowledge that many in the medical

community and in the wider public support our reform programme. We know that clearly from the listening exercise last year when many thousands of people contributed their views. Those views about the principles of what we are trying to achieve came through loud and clear. In the main, the concerns revolved around implementation. We believe that we have addressed those concerns in amendments to the Bill and in other announcements that we have made that are non-legislative in nature. We continue to believe that our plans for modernisation are essential if we are to put the NHS on a sustainable long-term footing. I will explain a few ways in which that is true, and will try to do so in clear, layman's language without resorting to departmental technical speak.

Without the Bill, Ministers would remain free to continue to micromanage the NHS. There would be no legally enforceable duties to tackle health inequalities as the Bill introduces such duties for the first time in this country. There would be no legally enforceable duties on quality improvement because it embeds quality improvement throughout the system. There would be no duties on NHS organisations to involve patients in decisions about their care. Failing organisations would continue to be propped up using taxpayers' money-the Bill tackles that problem in a creative way. Governments would be able to prioritise the private sector over the NHS-the Bill ensures that such behaviour is prohibited. Patients would continue to lack the means to hold the NHS to account because the Bill gives patients real power by establishing HealthWatch so that the interests of patients and the public can be championed throughout the NHS. Withdrawing the Bill would cause disruption and chaos at a time that the NHS most needs certainty about the future. As has been said today, the NHS is already in a state of change. That cannot be sustained indefinitely because it puts additional strain on management capacity and creates additional cost.

Lord Lester of Herne Hill: Does my noble friend agree that one of the vices in the amendment is that it would encourage judicial review proceedings and legal uncertainty? I say that as somebody who has taken advantage of the old wording to bring successful judicial review proceedings in Northern Ireland. The advantage of what we now have in the Bill is that it will not place judges in the position of seeking to run the health service, instead of Parliament, Ministers and the health authorities themselves.

Earl Howe: I defer completely to my noble friend, who is right to point out that one thing that we wish to avoid is a charter for a legal action and judicial review. I believe that we have avoided that because of the way in which accountability is now described in the Bill-or will shortly be described, when the amendments are passed. It is accountability primarily through the Secretary of State to Parliament. I thank the noble Lord for his observations.

6 pm

Baroness Jay of Paddington: The Minister has clarified the difficulty that I was in, partly because of the intervention from the noble Lord, Lord Lester, but also because of what the noble Baroness, Lady Williams, said. As I understand it, all their remarks are posited on the basis that the subsequent amendment, Amendment 5, will be accepted by the House. When they refer to the terms of the Bill, they are referring to the Bill as it now stands and not as it will, I hope, be amended in the conclusion of our next debate.

Earl Howe: I am grateful to the noble Baroness, who is of course quite right.

I have been handed a note, which says that when I said that there would be no legally enforceable duties on quality improvement, I should have clarified that that would have a follow-on. I should have said, "across the NHS system".

The noble Baroness, Lady Thornton, referred to potential privilege responses from the Commons. My noble friend the Leader of the House made a Written Statement last Thursday about the financial privilege of the House of Commons in which he drew attention to a paper by the Clerk of the Parliaments, available in the Library. I think that questions about procedure may be best directed to my noble friend, but I shall do my best to assist. The Clerk of the Parliaments makes it clear in his paper that,

> "until the Commons asserts its privilege, the Lords is fully entitled to debate and agree to amendments with privilege implications".

That is what we should do. I would much regret it if the House thought that I was trying to restrict its role of revision. The Marshalled List sets out more than 100 amendments in my name, tabled in response to debate in Committee, and if the House agrees to those amendments I can assure noble Lords that the Government will encourage the other place to accept them.

The essence of the noble Baroness's question is about privilege reasons for the Commons rejecting amendments proposed by this House, and on that I can say two things. First, any amendment with implications for public expenditure might involve privilege, but that is a matter for the Commons alone. Decisions on financial privilege

are for the Speaker of the Commons on advice from the Clerks of that House. If the Commons reject a Lords amendment in which the Speaker has determined that privilege is engaged, the only reason that it can send this House is a privilege reason. There is no discretion.

Secondly, this debate is by its nature premature. I hope that our debate and dialogue will lead to this Bill being sent to the Commons in a form that that House will accept. Until we see how Report unfolds, it is too early to speculate on the reaction from the Commons. One cannot have a reply to a question until the question has been asked.

Baroness Thornton: My question was actually about the Government's intentions. That was a very enlightening and helpful remark about privilege. The Speaker of the Commons will not presumably, by and large, take a view on privilege unless the Government ask him to. So my question was about the Government's intention on this matter.

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Earl Howe: I have taken advice on this, and I believe that what I am about to say will not mislead the House as I have been given this advice on authority. It is not for the Government to do anything; it is not within our power to do anything. The noble Lord, Lord Martin, who spoke last week on this matter, is par excellence an authority on this. A view is taken by the Clerks in another place on the amendments passed in this House as to whether privilege is engaged. The Speaker is then advised. The Government have no role in that process at all; it is a Commons privilege, not the Government's privilege.

I hope that what I have said will persuade your Lordships that the course down which the Opposition would wish to take us is the wrong one. The Bill, once amended-if that is your Lordships' wish-through the amendments that have been jointly agreed on a cross-party basis, will therefore be fit for purpose in clarifying beyond peradventure the Secretary of State's accountability for the health service and the exercise of his powers. With that, I hope that the noble Baroness, Lady Thornton, will feel able to withdraw her amendment.

Baroness Thornton: I thank the Minister for that response. I made it clear in my opening remarks that I would not seek to push the amendments to a Division, although

the remarks of the noble Baroness, Lady Williams, and the Minister made me wonder whether I ought to do so, because certain things that were said were not justified.

First, the noble Earl took us through a list of things that without the Bill would not be happening. On almost every single one, I thought that without the Bill you could do all those things. You do not actually need this Bill to do most of the things that the noble Earl listed as being desirable objectives. I am sure that we would agree about most of them being desirable objectives.

The noble Earl mentioned the listening exercise as being proof that this is not the unloved Bill that I would suggest it is. Only yesterday, a former special adviser to Downing Street said that the listening exercise was a tactic as part of managing the Bill. Frankly, I was horrified by that. If I had been Professor Steve Field or one of the 40-odd people who, with every good intention of doing a public service unpaid, gave their time to take part in that listening exercise, I would think that it was really shocking. So I think that the noble Earl should be careful about praying the listening exercise in aid in explaining how loved or unloved this Bill is.

It is time that we moved on. I intend to reserve my praise for the next debate and leave my criticisms in this debate. I intend to withdraw my amendment, even if the noble Earl will not withdraw the Bill.

Amendment 3 withdrawn.

Amendment 4 not moved.

Amendment 5

Moved by ***Earl Howe***

5: Clause 1, page 2, line 9, at end insert-

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"( ) The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England."

Earl Howe: My Lords, I beg to move Amendment 5. As noble Lords will be aware, and as I stated during our discussion on the previous group of amendments, a number of concerns were raised in Committee over the clauses relating to the Secretary of State's accountability for the health service. Since our collective discussion in November to withdraw amendments on this issue, pending a period of discussion and reflection, I have been meeting noble Lords to understand their concerns. Alongside the conversations that I have had with Peers, both individually and in groups, we have held two all-Peers seminars to try to reach consensus on what changes might be made to bring clarity. I am very grateful to all those who invested time and effort in this matter, which I know so many are passionate about.

I would particularly like to thank the noble Baroness, Lady Jay, and her colleagues on the Constitution Committee, who articulated their concerns about ministerial accountability so coherently in their two reports and proposed amendments. I believe, as had been suggested already, that the process that we have gone through has revealed the House of Lords at its best-working together to improve the Bill and achieve common ground. This amendment deals with the overarching accountability of Ministers for the health service, as set out in Clause 1. At this stage, we are taking this amendment on its own, but there are further amendments on related themes to follow. We should perhaps look at this amendment in that context.

However, I think I am right in saying that Clause 1 has attracted the most attention from Peers, and quite rightly so. It gives the Secretary of State a duty to,

> "continue the promotion in England of a comprehensive health service",

wording that can be traced back to the original 1946 NHS Act. Amendment 5 makes it clear that the Secretary of State will retain ministerial responsibility to Parliament for the health service. It has been this question of ministerial responsibility that has been such a cause of concern, and I am sincerely grateful to the noble Baroness and the Constitution Committee for drafting this amendment which, I hope, should serve to put everyone's minds at rest on this issue.

Noble Lords will recall the original suggestion made by my noble and learned friend Lord Mackay, which used "ultimate responsibility to Parliament". I should explain that we have gone with the formulation "ministerial responsibility to Parliament" because it more clearly refers to the constitutional principle of ministerial responsibility. That is to say: Ministers are responsible, accountable and answerable to Parliament for their policies, decisions and actions-and, indeed, those of their departments. The principle is recognised by Parliament and the courts, and, as the Constitution Committee notes, in the *Ministerial Code*. The amendment reflects the position that as a result of the

principle and the duties and powers imposed by NHS legislation, the Secretary of State for Health is responsible and accountable to Parliament for the health service in England, even if he or his department do not directly provide or manage NHS services. It has never in fact

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been the Government's intention to diminish ministerial responsibility to Parliament, so I can offer my wholehearted endorsement of and support for this amendment. I hope that your Lordships will feel able to do so as well.

Baroness Jay of Paddington: My Lords, I am grateful to the Minister for the way in which he introduced this amendment because, as he graciously expressed, this is not really a government amendment but an amendment by the Constitution Committee, which it invites your Lordships to agree. Of course, with a government Minister at the head of those supporting the amendment, I hope that will in itself be unarguable. It is right that the Constitution Committee's position should be explained a little more in the context of this first amendment in relation to the Secretary of State's responsibilities, and I am glad that it has been put in a group on its own. It is a very significant amendment, and not just because it alters fundamentally the expression of the Secretary of State's responsibilities from the original Bill. It is also significant because of the process by which it has been reached-the Minister has already alluded to this, and I certainly express my enthusiasm for the process-and in which the House has undertaken this work.

The terms of the amendment are simple but very powerful:

"The Secretary of State retains ministerial responsibility to Parliament for the provision"-

that is always the difficult word-

"of the health service in England".

It is simple but powerful because, frankly, so is the concept of ministerial responsibility, although we argue about it all the time. It is a basic concept which, as the Minister has said, has been expressed in all NHS legislation, and quite rightly in my view, since the first Act 60 years ago. Without wishing to appear to give a civics lesson to the House, it is worth saying that the Constitution Committee has agreed that, in its terms, individual ministerial responsibility means that Ministers must be accountable and answerable to Parliament for their-and their departments' and agencies'-policies, decisions and actions. I think that is widely accepted. There is no constitutional distinction between

ministerial responsibility, accountability and answerability; they are all aspects of the same constitutional fact.

This Bill was worrying, because it was the first in which there was not an explicit provision on political and legal accountability. The Constitution Committee, as the noble Earl said, raised serious concerns about this in the initial report that we gave to the House before Second Reading. There we said that the Bill, if enacted in its present form, risks,

> "diluting the Government's constitutional responsibilities",

for the NHS. It is worth reminding your Lordships that those responsibilities which the Minister should retain embrace the accountability to Parliament for the vast public expenditure that the NHS undertakes, and the provision of its multitude of services.

6.15 pm

At that stage, the Constitution Committee suggested that an easy solution was simply to retain the unambiguous wording which exists in the present 2006 Act. The

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Government rejected that proposal and on that occasion the noble Earl-rather differently from what he has said today, but I entirely understand his change of position-echoed the Secretary of State, Mr Lansley, in insisting that although the Bill changed the forms and systems of accountability he, the Secretary of State, would continue to have overall responsibility. Those were, in a sense, the terms of the amendment proposed in Committee by the noble and learned Lord, Lord Mackay of Clashfern.

The Government also wanted to make it clear that Ministers should not try to micromanage the health service and that primary responsibility for service provision under their changes would be devolved to independent organisations. Again, the Minister has referred to that this afternoon. However, as we know, it became very clear during Second Reading and the subsequent Committee that many noble Lords, in every part of the House, stood with the Constitution Committee in its anxieties. Although they may not have shared them exactly, they did have their concerns. As the noble Earl, Lord Howe, has rightly said, he very helpfully suggested that this should be taken off the Floor of the House, and has tried very strongly to try to reach the consensus which we have, I hope, come to before this next stage of the Bill. I pay tribute to him for that.

The Constitution Committee, as the noble Earl said, was invited formally to look at the issues again. We duly did so, and our second report was published just before Christmas. In it, we continued to argue the constitutional necessity for an explicit reference to ministerial accountability to be in the Bill. We therefore propose the wording and concept of Amendment 5, which is before your Lordships. I hope that those in the House who have had the time to read it have found it useful to look at Appendix 1 of the December report, which sets out our understanding of ministerial responsibility as it applies to the duties of Secretaries of State. Although I hope it will not take long, perhaps I might quote somewhat extensively from that appendix because it covers some of the points which have been raised by noble Lords in debate, and which the Government relied on until they decided to accept this amendment.

The appendix says:

"It is essential to bear in mind that (i) what ministers are constitutionally responsible to Parliament for and (ii) what ministers themselves do may not be the same. The distinction matters in the context of the Health and Social Care Bill for the following reason: removing from the Secretary of State the duty to provide health services does not mean that the Secretary of State no longer remains constitutionally responsible to Parliament for the provision of health services. Likewise, a provision to the effect that the Secretary of State remains constitutionally responsible to Parliament for the provision of health services does not mean that the Secretary of State must himself provide the services. It is because of a failure to bear this distinction in mind that much of the confusion about this matter has arisen".

One other important point in the appendix is worth repeating. In addition,

> "there is a constitutionally significant difference between ministerial responsibility to Parliament and the accountability of a public body (such as the NHS Commissioning Board)"-

as it will be-

> "to a minister. In constitutional terms the latter"-

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that is, the new independent bodies-

"can never be a substitute for the former"-

that is, the responsibility to Parliament-because in the latter case the body in question does not have any accountability or reference to Parliament.

That clearly sets out the problems which the Constitution Committee felt expressed an answer to the problems that have arisen all around the House. The noble Earl, Lord Howe, has already explained why the Government have decided to support Amendment 5. Again, I must pay very warm tribute to his flexibility and availability during all the meetings and exchanges of letters that have taken place since the Committee stage. The noble Earl has been enormously generous with his time, both to the Constitution Committee and to individual Members. Most importantly, he also made it possible for the Bill team officials from the Department of Health and parliamentary counsel to hold discussions with the legal advisers to the Constitution Committee. I thank those legal advisers, Professor Richard Rawlings and Professor Adam Tomkins, for their sterling work on the constitutional detail of all this and for formulating various alternative proposals before the committee itself decided to agree Amendment 5, which is tabled today. I was delighted when on 1 February, after several iterations of the content and wording of this amendment since Christmas, the Minister wrote to all Peers saying that the Government supported not only the spirit but the letter of the Constitution Committee's recommended change to Clause 1.

I notice that the Minister used the expression "the House of Lords at its best". I am always wary of our tendency to be self-congratulatory, but the process of achieving consensus on this important amendment has been an example of House of Lords effectiveness. It demonstrates a useful extra role for Select Committees, and I hope that that can be used again in different contexts. It has also demonstrated the virtue of informal cross-party analysis, discussion and agreement.

As we all know and as my noble friend Lady Thornton has rightly drawn attention to again today, this is an extremely controversial Bill with an unhappy history and possibly an unhappy future. However, on the fundamental issue of maintaining ministerial responsibility to Parliament for our biggest public service, Amendment 5 has achieved that. To put it in shorthand terms, it has at least made it less likely that the NHS will become simply a giant quango. I will not be surprised if my noble friend Lady Thornton on the Front Bench says again that nothing can be done to make the Bill acceptable, but in the spirit of improvement I commend Amendment 5 to the House.

Lord Newton of Braintree: My Lords, I assure the House that I rise only briefly. On this occasion, unlike two amendments ago, I have three excuses for doing so, not just two. The first is that I do not always want to be a troublemaker. The second is that I and my

noble friend Lord Mawhinney expressed the view at an earlier stage that resistance to an amendment of this kind would be absurd because the amendment reflects the reality of the world. The third I have already referred to: that in the absence of my noble and learned friend Lord Mackay, I feel that I need to

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say a word not quite on his behalf-that would be lèse-majesté-but at least in his interests, as he has been referred to a lot. I congratulate the noble Baroness and her committee on what has been a remarkably productive role since the endless debates on these matters that we had at the beginning of Committee. It is a great tribute to her. She will not have been able to do this on the whole of the Bill, as she implicitly acknowledged just now, but to have produced this degree of sweetness and light on this issue is a near-miraculous achievement for which she deserves our thanks; she certainly has mine.

Along with that go thanks to others, including my noble and learned friend and many others who have taken part in those meetings, not least-as the noble Baroness has said and as I want to say-the Minister, who has successfully shifted people, who seemed two or three months ago to be dug in a trench in which they were going to die, to accept the terms and the realism of the amendment. That is a great credit to him and ultimately to the colleagues at the other end of the Corridor who allowed him to persuade them.

As the noble Baroness said, we can regard this as a real success for the collective wisdom of this House. I just hope that that will be sustained during the rest of the discussions on the Bill.

Lord Owen: My Lords, I shall not detain your Lordships, but the noble Lord, Lord Hennessy, has asked me to speak on his behalf. I find no reason to disagree with anything that has been said, particularly by the noble Baroness, Lady Jay.

The Minister and I are going to disagree on substantial parts of the Bill-and a profound disagreement it is-but right from the moment when the noble Lord, Lord Hennessy, and I negotiated with him, he always accepted that this was an important constitutional and parliamentary point. He expressed readiness to enter into a novel arrangement, which we very nearly reached, but instead it has come around by another mechanism. At all stages, he has treated all of us, Peers and the House itself, with the greatest respect, courtesy and diligence. For that, I thank him on behalf of everyone.

Lord Mawhinney: My Lords, having taken up your Lordships' time both at Second Reading and in Committee, I want to chip in at this significant point in this particularly

significant clause. The noble Baroness, Lady Jay of Paddington, dealt beautifully, succinctly and with clarity with the constitutional importance and relevance of the amendment. I pay tribute to the work that she and her colleagues have done and the clarity with which she was able to persuade us in her contribution.

Colleagues will recall that I did not take the constitutional high ground in my concerns about what was originally expressed. I started from the other end of the spectrum. Whatever we may say constitutionally and whatever the professorial advice, my former constituents did not believe a word of it. They expected the Secretary of State and Ministers to be responsible. That was the argument from the grass roots that I tried to deploy to persuade the Minister to look at this again. I think that I was maybe the first-I was

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certainly one of the first-to suggest that all this should be taken away from Committee, we should not be tempted into a vote and we should think further about it.

I am delighted with the outcome on behalf of all my former constituents and indeed everyone else in the country, because we are now all on the same page. We are all now saying the same thing. Some of us have arrived there by high constitutional means, others from the grubby reality of the streets. The Secretary of State is the boss and is held accountable. He gets some credit for the successes and all the blame for the failures. That is how it has always been and, thanks to this amendment, it is how it will continue to be. Everyone will think that this is a great outbreak of success and common sense.

I pay tribute to the Minister. My noble friend Lord Newton has just said that the Minister's colleagues will also have had to have been persuaded to this point. I hope that I will not diminish the sense of satisfaction in the House if I say that perhaps the Minister will have had a more important part to play in that process than the debates in this House.

Whether or not this is your Lordships' House at its best, I do not care to judge. However, I will tell those of your Lordships who have not had the privilege of serving in the other place that this could never have happened there-never have happened. That is because the other place is infected with a degree of party political commitment that is frequently, though not always, spared at this end of the Corridor. Incidentally, for those who do not share my view and would like to see an elected Chamber, I gently point out that if what I am saying is true, this amendment today would never have been possible in the new, so-called "modernised" Chamber that is envisaged.

I refer to the introduction of the noble Baroness, Lady Thornton, to the previous set of amendments. I pray in aid the fact that she said that she would take responses in this debate rather than in the previous debate. She mentioned me by name and I thank her for that. She reflected accurately what I have just explained at some length. However, I will give her something else that she can quote accurately in the future. I congratulate my noble friend the Minister. He has done an excellent job, not for the benefit of the party, the Government or even the health service, but for the country. I am among those who feel indebted to him for what he has done and the spirit that he has adopted. I hope that, on reflection, the noble Baroness will realise that her introductory three minutes of an extremely party political nature were seriously out of sync with the consensus mood of the House at this time.

6.30 pm

Baroness Williams of Crosby: My Lords, may I, too, say a word or two about this brilliant process? It is important to say that at the moment we are discussing Amendment 5, for which the noble Baroness, Lady Jay, has a large and commendable share of responsibility. However, the constitutional agreement that we have reached goes a great deal further, embracing Amendment 6 and the amendments to Clauses 4 and 12, which we will discuss a little later.

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We are discussing much more than even Clause 5. A whole range of substantial constitutional amendments go a long way to sustaining what the noble Lord, Lord Hennessy, expressed wonderfully when he spoke about this constitutional move a long time ago. In particular, the amendments put the concept of the NHS constitution at the centre of the future of the NHS. At Second Reading, the noble Lord, Lord Hennessy, used a phrase about the 1946 Act that I thought was absolutely right. He said that it was as close to institutionalised altruism as we have ever come. "Institutionalised altruism" is a wonderful phrase. It reminded me-my memory goes back this far-of another phrase used by another great warrior for the NHS, Professor Richard Titmuss of the London School of Economics. He gave a book that he wrote about blood donation the wonderful title *The Gift Relationship*.

It is appropriate to say to those who talk about society that a good society must be underpinned by the concept of mutual altruism within it. Nothing represents that more

clearly than the National Health Service has done. I very much hope that all those who share that view will, within their own parties, make it clear that there is a greater responsibility on us than to indulge in party back-slapping and bickering; and that is to make sure, between all of us, that the NHS thrives and looks after the health and care of the people of England, and of Britain more widely.

However, having said that, I want to say two further things. As the follow-up report of the Constitution Committee indicates, there was a distinct gap following the letter that was originally sent by the noble Earl, Lord Howe, about the constitutional changes. Subsequently, on 2 November, when we were in the early stages of Committee, there was a substantial shift by the noble Earl and the department, away from a somewhat small-scale response to this much more generous and widespread response on all the constitutional issues, some of which we have still to debate later this evening. The reason why was so important-and the reason why the House of Lords should not sell itself short-is that in that gap between 10 October and 2 November, the very imaginative House of Lords moots were held, with all Peers invited, led by the noble Earl, Lord Howe. These shifted the whole situation further towards the concept of a constitutionally shared settlement. That was a contribution by many Members of this House of all parties and, including the Cross-Benchers, of none. It was significant. It expressed the serious attempt to reach a conclusion that was based on consensus in this House. I hope that consensus will last.

In passing, I mention that we need to look at the whole package to see just what an amazingly substantial and imaginative idea it is. Although we will no doubt go on to argue, as we should, about the issues that remain out there-such as competition, conflicts of interest and others on which we have strongly held views-we should, in sitting down this evening, be very pleased to be able to say that we have achieved this much with the great help of the Constitution Committee and others. Those who took part have every reason to feel that they have been part of a substantial experiment that I hope will be followed further in Parliament, not least in this House.

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Lord Laming: My Lords, may I briefly add my thanks to the Minister and the Constitution Committee? Its second report was particularly helpful. To follow the point made by the noble Baroness, Lady Williams, it is right to see Amendment 5 in the context of some coherence over how this accountability will work, not just at ministerial

level but at board level. There will be further amendments. At this stage, suffice to say that the Constitution Committee looked at these matters in the broadest possible way to ensure that-whether in terms of autonomy or commissioning-there would be a coherence to the way in which accountability would continue to be established in the National Health Service; and, in particular, that those responsible for commissioning and other important work follow through their tasks in relation to ministerial accountability to Parliament.

The second report of the Constitution Committee was a model of how such matters can be dealt with coherently, succinctly and very clearly. We are indebted to the Minister for giving us the opportunity to consider that more carefully; and to the Committee for its work, which took us forward enormously and has brought us to where we are today. I am grateful and I support the amendment.

Baroness Pitkeathley: My Lords, far be it from me to cast a pall over the House of Lords at its best. I join others in being glad about the consensus and in congratulating the Constitution Committee. I also congratulate the Convenor on the part that he played in getting the consensus. It is a privilege to follow him.

I join the noble Baroness, Lady Williams, in hoping that the consensus can continue but I have to remind the House of how the Bill is viewed out there. It is deeply unpopular with many of the people who will be required to make it work. They will make it work because that is what the workforce of the health service does and always has done in the most difficult of situations. However, it is looking to us to make those difficulties as few as we possibly can. Therefore, in congratulating ourselves on reaching where we have on this issue, let us remember the task before us.

Baroness Young of Old Scone: My Lords, I am afraid that I will be even more discordant. I do not want to denigrate the congratulations that have been offered to the noble Baroness, Lady Jay, and her colleagues and the process that has been gone through to reach agreement on this amendment. However, I share the view of the noble Baroness, Lady Pitkeathley, that we must not forget not only how deeply unpopular the Bill is but that it is flawed.

I had not intended to speak on this amendment but I cannot let the moment pass as I think that the noble Baroness, Lady Jay, referred to a spirit of improvement that she was seeking in moving this amendment. However, we have to remember that the improvement is a bit like trying to paint the face of a harlot; at the end of the day, it is still the face of a harlot, no matter how improved. We are seeing real impacts on healthcare in this country as a result of the Bill, as we speak. I come from a background of having run health services for 20 years. I have also been the regulator for health and

social care and am now part of a patients' organisation.

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Patients are telling me that we are seeing the fragmentation of responsibility for the commissioning of healthcare and that services are suffering as a result of the financial squeeze; for example, diabetic specialist nurses are disappearing and patient education is being cut. The things that are important for the quality of care are being removed.

I am experiencing a huge loss of momentum in getting any change implemented in the care for people with diabetes. Whenever I speak to the Secretary of State, he tells me that it is no longer his responsibility and that I should talk to the NHS Commissioning Board. However, when I speak to the NHS Commissioning Board, staff say, "We are still working out how we do this". When you talk to clinical commissioning groups, they are still not clear about the framework in which they are operating. Therefore, we are losing one, two or three years of headway on issues where there needs to be real improvement for patients.

Because of the preoccupation with reform, we are seeing a lack of real focus on the task in hand, which is how we make the health service more efficient. The Minister and the Secretary of State have repeatedly told me that these reforms will deliver that necessary improvement in care and efficiency. However, my experience over 40 years leads me to believe that that is not the case. In saying that, I am not making a political point; I speak from my knowledge of what is happening in healthcare. We will continue to try to improve the Bill because we are good and honest toilers in the House of Lords, but we are trying to improve something that is deeply flawed.

Baroness Thornton: My Lords, we must be thankful to my noble friend Lady Jay and the Constitution Committee for their initial work and their second report, which has enabled us to reach the point that we have. I am grateful to my noble friend Lady Pitkeathley and the noble Baroness, Lady Young, for saving us from the gloopy treacle of self-satisfaction into which we were sinking, to which my noble friend Lady Jay referred.

I, too, thank the noble Lord, Lord Laming, the Convenor of the Cross Benches, for chairing the seminars that have been referred to. We all know that chairing seminars attended by opinionated Members of this House and lawyers is not an easy task. He did an excellent job and led us gently towards the consensus that has resulted in the amendments being tabled that we are discussing. I pay tribute to the noble Baroness, Lady Williams, the noble Lords, Lord Hennessy and Lord Owen, whose wisdom brought the great importance of this issue to the attention of the House.

We support this amendment as it is clearly an improvement on what was in the Bill originally. We are still perplexed as to why we could not simply have kept the 2006 wording, but we are where we are. However, I wish to repeat the question that I have already put to the Minister. The Secretary of State has let it be known that he does not think that this measure makes a difference. That shows no respect for the work that we have undertaken and the place in which we find ourselves. Therefore, I should like clarification on that point. We need to know why that is the case. This

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measure constitutes a significant change because, as I think the noble Baroness, Lady Williams, said, it will have repercussions on other parts of the Bill. I welcome that and hope that it is the case. We need to look at the changes proposed in this and the following amendments as they should make easier our job of testing other parts of the Bill against them.

I say to the noble Lord, Lord Mawhinney, that this is still a very political Bill. The noble Lord's party and the Liberal Democrats pushed the original drafting on the Secretary of State's powers through the Commons. I have tried to keep my remarks about the highly politicised nature of the Bill separate from this debate because I thought it was important that we should also recognise the work that has gone on and the consensus that we have reached in this House. That is due to a combination of clarity, wisdom and our consideration of the Constitution Committee's report. I compliment noble Lords on my own Benches because we were determined not to accept the well meaning and imaginative original proposal of the noble and learned Lord, Lord Mackay of Clashfern. We had very trenchant support from noble Lords such as the noble Lord, Lord Owen. The Minister, in his wisdom, took these clauses off the Floor of the House and we are now where we are. That is a great credit to everybody concerned, including my own party. Therefore, we are very happy to welcome this amendment and hope that it bodes well for our future discussions on Report.

6.45 pm

Earl Howe: My Lords, I think that it only remains for me to thank noble Lords who have spoken in this debate. I listened with care and respect to the noble Baronesses, Lady Pitkeathley and Lady Young, as I always do. I understand their concerns. I think that some of them are misplaced but they are right that any transition brings with it uncertainty and a certain amount of disruption. That is regrettable but all I can say is that the picture painted by the noble Baroness, Lady Young, is not representative of the whole of the NHS. She is right; there are difficulties. However, we are very confident that they can be resolved in short order.

The noble Baroness, Lady Thornton, asked me whether the Secretary of State believes that this amendment makes a difference. Yes, he does because he recognised that this House perceived a lack of clarity in the Bill. He welcomes the fact that this situation has been resolved by means of consensus. Therefore, I reassure her on that point. I thank all noble Lords who have spoken so supportively in favour of this amendment, especially the noble Baroness, Lady Jay, whose work, along with that of her committee, proved so indispensable to the consensus to which I have just referred. I thank the noble Lord, Lord Owen, for all that he said. I thank the noble Lord, Lord Laming, for his contribution not just today but in his role of chairing the all-Peer seminars that brought us to this conclusion. I thank my noble friends Lord Newton and Lord Mawhinney and the noble Baroness, Lady Williams, for their wise and generous observations; and, indeed, I thank the noble Baroness, Lady Thornton, once again. I commend the amendment.

Amendment 5 agreed.

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Clause 2 : The Secretary of State's duty as to improvement in quality of services

Amendment 5A

Moved by ***Baroness Royall of Blaisdon***

5A: Clause 2, page 2, line 33, at end insert, "and report annually in Parliament on the progress towards their development"

Baroness Royall of Blaisdon: My Lords, I shall speak also to Amendment 255A. Both amendments relate to quality standards.

The Government must ensure that the newly structured NHS delivers high-quality care to all patients across England. The much disputed reforms must not create a situation that amplifies the differences in quality of care that patients receive in different parts of the country-that is to say, an amplified postcode lottery would be intolerable. Clear national guidelines, such as the quality standards being produced by NICE, are urgently needed to define the quality of care that local authorities and clinical commissioning groups should achieve.

However, the delayed development of NICE quality standards for prostate cancer, as well as recent decisions not to recommend new treatments for men at the end stages of the disease, threaten to leave prostate cancer behind and increase the variation in the quality of care that men receive across the country. Historically, men with prostate cancer have suffered from a legacy of neglect. Although recent improvements have been made in the quality of care that men receive, this progress is at risk, and that is unacceptable. Patients should receive the same high-quality care regardless of where they live. I am, as ever, grateful to the excellent Prostate Cancer Charity for its help and support.

The Bill presents an opportunity for NICE to establish national quality standards that set out the quality of care that patients should receive across England. Having these standards in place for prostate cancer and other conditions will ensure that clinical commissioning groups and cancer networks will be able to benchmark the services that they commission and evaluate the quality of care that they provide. The standards will also help local authorities to scrutinise health services effectively and allow patients to check that they are receiving higher quality care. The quality standard for prostate cancer was prioritised for development in 2011 in the Government's *Improving Outcomes: A Strategy for Cancer*. However, this has been delayed by NICE and the quality standard for prostate cancer will now not be published until the end of 2013 at the earliest. I am extremely concerned that development of quality standards is already being delayed for priority areas, and this could be an indication of future delay and barriers to driving up the quality of care within the new NHS.

When guidelines on prostate cancer care have been delayed in the past, it has led to men with prostate cancer reporting a significantly worse experience of care than men with other common cancers. We cannot afford to repeat those mistakes, particularly in the light of the new localised approach to healthcare set out in the Bill. The Minister's response to my

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amendment in Committee was disappointing, given that he said it will take five years to develop the full set of quality standards. While the six months suggested in that amendment is a tight timescale, five years is too long to wait for these crucial benchmarks of quality care.

This amendment to Clause 2-which outlines the Secretary of State's duty to improve the quality of services-would require him to report annually on the progress towards the development of quality standards. This would help. It is not an onerous requirement and

would help ensure that the standards are prioritised and that Parliament could scrutinise their progress. Quality standards are meant to be patient-facing documents and an amendment to Clause 233 that would require the NHS Commissioning Board and/or the Department of Health to maintain a publicly available information source of each quality standard would also help. This would allow patients and professionals to see real-time information and scrutinise the progress of these important standards. I beg to move.

Baroness Masham of Ilton: My Lords, I strongly support the amendment. Yesterday, I went to a meeting on prostate cancer, a disease that 10,000 people a year die from unnecessarily because of late diagnosis. I should like to tell noble Lords a small story about a friend of mine. He went three times to his local surgery in north Yorkshire and was sent away. His son was worried because there were symptoms, so he took him down here to London. He was diagnosed with prostate cancer straight away in a private clinic, but it had gone through to his bones because of late diagnosis. The treatment is much more expensive, so if only there was a standard throughout the country. Therefore, this is a very important amendment.

Baroness Tyler of Enfield: My Lords, I also support the amendment on prostate cancer, which is a very important area. However, I wish to support the government amendments in this group-Amendments 68, 112 and 144, to which my name is also attached. These amendments all relate to reducing health inequalities and, in a nutshell, create a new duty on the Secretary of State, the NHS Commissioning Board and the clinical commissioning groups to report annually on their progress in tackling health inequalities.

As this is Report stage I will not rehearse the stark statistics on life expectancy that we heard during earlier stages of the Bill. We also heard compelling accounts of what needs to happen to improve health outcomes for those particularly vulnerable and disadvantaged groups whose patterns of usage of the health service often take a different form from those of other sections of the population. These groups include the homeless, those with mental health problems and others whom we heard about earlier.

As I recognised in Committee, the explicit duties on health inequalities which the original version of the Bill placed for the first time on the Secretary of State, Commissioning Board and CCGs were landmark duties. They certainly represented a major shift from the current position. However, as a number of noble Lords, me included, argued in Committee, those duties did

not go far enough, and we called for their strengthening, particularly so that CCGs and

other parts of the structure would be required not simply to "have regard" to the need to reduce health inequalities but to act to secure real improvements in terms of access to health services as well as outcomes. It is also critical that those bodies should account publicly for their progress in so doing.

I thank very much my noble friend the Minister for listening and acting. The nub of these amendments is that they shine a clear spotlight on health inequalities by introducing real transparency and accountability at national and local levels. I very much hope that the amendments will be instrumental in changing the culture so that things such as sharing good practice in tackling health inequalities become a key part of workforce training and very much part of the currency of everyday language in the NHS.

These amendments have the potential to make a reality of the words in the public health White Paper that spoke of,

> "improving the health of the poorest, fastest".

It is for those reasons that I support these amendments, and I thank the Minister for tabling them.

Lord Harris of Haringey: My Lords, I support the amendments in this group because I believe that it is important that we look at the mechanisms that will be embedded in the Bill, assuming that it eventually receives Royal Assent in some form, and that will in practice drive change in the direction that we all want. That includes improving the quality of the care offered, and it means addressing the issues of health inequality to which the noble Baroness, Lady Tyler, referred.

One of the omissions from the Bill is that, apart from placing some general duties on the various bits of the NHS, there is very little about demonstrating how those duties will then be exercised or creating a mechanism for assessing that. The amendment, which talks about reporting annually to Parliament on the progress made, seems an essential first step in making sure that that happens.

The reports on inequalities will be increasingly important in this area. However, Amendment 112, dealing with CCGs' annual reports on how they have discharged their duty to reduce inequalities, raises another question, and this comes back to the issue of what will be the catchment areas of individual CCGs. Unless there is far more central direction than I have understood-and perhaps the Minister can reassure us on that-it seems likely that there will be, to use an unpleasant term, ghettoisation in some CCGs.

7 pm

In some local authority areas, the easier bits of the patch will have one CCG and another will cover the others. That is likely to mean that the areas covered by those two different CCGs are rather more homogeneous than might otherwise be the case. If one CCG covered that area, the duty to make progress on health inequality would be clearer. If we are talking about smaller populations served, it is more likely that they will be homogeneous and that there will therefore be less inequality to address. The question will be whether

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there will be enough pressure within the system to ensure that the inequalities in health outcome between different CCG areas will be addressed. It is all very well to place a duty on a CCG which covers, say, the people of Tottenham in north London, where there are tremendous problems of health status, life expectancy and so on, to report on what it is doing to eliminate health inequality in its patch, but if the nature of that patch is such that it is already deprived in terms of both economic indicators and health outcomes, what will be the driver to ensure that the inequality of that area compared with others is addressed?

Who will own the strategy within regions and parts of the country to address issues such as health inequality and clinical standards? If the answer is that that this will all be done by the NHS Commissioning Board, that is a wonderful answer and tells us what an important body the NHS Commissioning Board will be. How will that be operationalised? What mechanism will drive that? Before you know it, you are talking about a regional and area infrastructure no less baroque than anything we have seen in the past. Otherwise, it cannot happen. What will be done to operationalise the drivers to make the improvements happen? It will not be sufficient to place a duty on everyone to report on what they have done, although that is valuable and worth while in itself. What will be the duty to address issues between localities? You can address all the inequality you want within those areas, but if the outcomes are already much lower in those areas, will there be enough infrastructure around the NHS Commissioning Board to address the problem of the inequalities between the different areas?

Baroness Finlay of Llandaff: I support all the amendments. I am glad to read the government amendments, which will obviously be accepted across the House, but the other amendments are also important. I draw attention to one aspect. I do not understand how we can expect GPs to do it all. We are expecting them to lead on commissioning. I have been asking about that extensively and have had conversations with the Royal College of General Practitioners but have not been able to find a clear example where general practitioners have led commissioning across a comprehensive

range of services for some time and that has been demonstrated to be successful. I would be very grateful to hear that I am completely wrong; that would be reassuring to know; but I am worried.

As I said earlier, patients present completely undifferentiated to general practitioners. The diagnostic burden on GPs to get it right is huge, because they are the point of entry. They are either the gatekeeper or the gate opener. Their role should be the gate opener, and there are real conflicts if they are charged with being the gatekeeper at the same time. Unless the diagnosis is accurate, everything that follows fails. I am concerned that the inequalities and range of standards to date will not be improved by the increased workload burden on general practitioners. I wonder if that, in part, is behind some of the objections emerging from GPs who have previously been quiet about the Bill, because they are becoming frightened that they cannot fulfil their clinical duty as well as their managerial commissioning duty.

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Lord Hunt of Kings Heath: My Lords, the government amendments on health inequalities are welcome. I take this opportunity to ask the noble Earl about clinical commissioning groups. Has he given further consideration to the links between health and well-being boards and clinical commissioning groups? He will recall the debate in Committee, when what I thought was a persuasive argument was made that to ensure that the links between clinical commissioning groups and local authorities taking on public health responsibilities were as strong as possible, it would be a good idea if a local authority nominee from the principal local authority served on the board of the clinical commissioning group.

My noble friend Lord Harris suggests in his comments about population coverage by clinical commissioning groups that there will be a grammar school-type impact, a creaming off of patients by some clinical commissioning groups so that the remainder will be left in other clinical commissioning groups. There will be areas of a city or locality where the health inequalities and morbidity and fatality ratios will cause a great deal of concern. It would be good to hear some assessment of that from the noble Earl. We have seen mapping of clinical commissioning groups in different parts of the country and they look weird and wonderful. They are not aligned to electoral wards and it will be very difficult to plan sensible provision of services because there is no geographical alignment.

I also ask the noble Earl, Lord Howe, to follow on from the remarks of the noble Baroness, Lady Finlay. We hear very little about primary care performance in our debate, but when I think back to the original speeches made by Mr Lansley, the whole purpose of the reforms is about GP performance. The argument is that GPs are responsible for most expenditure through referrals or prescribing, and that if you give them the budget, they will therefore be much more responsible in their behaviour. We have yet to be told how a clinical commissioning group will influence the behaviour of GPs within it. I know that that is a concern among the leaders of clinical commissioning groups.

If, for example, a clinical commissioning group has reached an agreement with providers, NHS trusts and NHS foundation trusts, on a shared risk approach to demand management-which I hope will be the outcome of most of these agreements-what on earth do you do if some GPs do not exercise responsibility over their referral or prescribing performance? We know that the variation in quality among GPs is very wide. What are the levers that will bring poorly performing GPs to the table? The leverage that clinical commissioning groups have is very limited. On balance, I think it would have been better if they had had the contracts of GPs. I know that there is an issue about Chinese walls and conflicts of interest, but the fact is that the contracts of GPs will be with the branch office of the national Commissioning Board. Therefore, the levers that the clinical commissioning groups have are likely to be very limited.

Then we come to the issue of, for example, prostate cancer. I very much agree with and support my noble friend Lady Royall on the need for quality standards and I hope that NICE will get a move on in relation to

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this. However, as my noble friend Lord Harris said, underpinning an argument about prostate cancer is the question of how you make such a standard work at the local level. If there is to be a quality standard, I doubt very much whether it will simply be confined to what an NHS hospital, a clinical commissioning group or a GP is expected to do. The quality standard will look at an integrated approach at the local level which will straddle various features of the architecture of the NHS locally. It might even have some regional aspects too where an input needs to be made.

Therefore, the question is: who on earth at the local level is supposed to sign that off? Who is going to take the leadership role? The clinical commissioning groups will be far too small to do that within a locality, so either they will come together and agree a strategy that will cover a sufficiently large population or, as I suspect, the national Commissioning Board will have to do it itself. I think that we will come on to these

debates when we deal with the role of the national Commissioning Board. We have all been highly entertained by the paper produced by Sir David Nicholson showing the less bureaucratic approach that the Government have adopted in relation to the health service with the various layers of bureaucracy that are being brought in. However, I am still left completely clueless about who at that sub-regional level, where so many critical decisions have to be made, is going to take responsibility. We know that in relation to prostate cancer much more needs to be done.

The noble Earl will remember the debates that we had on prostate cancer 10 years ago. He will remember the controversy over testing and how noble Lords were very keen to put their point of view across. That has rather gone away and I think that it has been replaced by a much more informed debate about a cancer on which we know we could do very much more and on which we know there has to be education in the public domain.

I very much support my noble friend in what she is seeking to do but it also raises the issue that the noble Earl's amendments touch on-that is, the architecture surrounding how a quality standard is implemented in the future, assuming that NICE is able to produce that standard as quickly as possible.

Earl Howe: My Lords, I am grateful to noble Lords for some very valuable contributions to this debate, which has ranged quite widely. I think that the first thing we can all do is agree on the importance of reducing health inequalities and developing NICE quality standards, which was where we began with the noble Baroness, Lady Royall. She is right that the Bill presents a major opportunity to drive up quality in the NHS, not least through the development of NICE quality standards.

The noble Baroness expressed her concern about the time that it is likely to take for this library of quality standards to be rolled out. I completely understand her desire to have NICE working quickly and effectively in producing quality standards. Against that, I simply say that we have to balance the need for speed with the need to produce standards of a high quality. We have

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already set NICE a challenging programme to produce the quality standards and we have to recognise that, if it is to do the job well, it cannot be done in a hurry.

However, we continue to believe that the programme is ideally placed to deliver a steady stream of quality standards over the agreed timescales. That will lead to a comprehensive library of quality standards, to which she referred, within five years. Of

course, I understand that that timescale is disappointing. However, I simply say that, while the quality standard for prostate cancer, in particular, is clearly important, there are many things that we can do, and are doing, to improve the care of cancer patients in the NHS, and we have recently debated some of those in your Lordships' House.

7.15 pm

Perhaps I may turn to the amendments that the noble Baroness tabled. I appreciate that many people have an interest in the programme of developing NICE quality standards and in NICE's work generally. We have thought about this and I hope that I can provide some reassurance.

First, the Bill already states that NICE must lay before Parliament an annual report setting out how it is exercising its functions. This will provide a clear mechanism for patients, clinicians and other interested parties to see how it is taking forward its various functions, including its role in developing quality standards.

Secondly, the Secretary of State must also produce an annual report on the performance of the health service in England. We tabled amendments ahead of this Report stage to ensure that, in particular, that report will give his assessment of how effectively he has discharged his duties regarding improvement of quality and reducing health inequalities.

Thirdly, the Secretary of State will also have a duty to keep under review the effectiveness of NICE's exercise of its functions, and he can include his views on this in his annual report. This could include his views as to how well NICE has performed its functions in relation to developing quality standards.

Therefore, although I have a good deal of sympathy with the noble Baroness in what she seeks to achieve, I suggest that in fact her amendments are unnecessary.

The noble Lord, Lord Harris, asked me about clinical commissioning groups and referred to their geographic coverage. He will know that each CCG will be accountable for the outcomes that it achieves against the commissioning outcomes framework, which is under development. The CCGs will be supported in their efforts to improve quality by the NHS Commissioning Board, whose job it will be to issue commissioning guidance, informed, among other things, by NICE quality standards.

I do not agree with the noble Lord that CCGs are likely to be ghettoes. Across many clinical areas, they will collaborate to serve the needs of patients over an area wider than that of just a single CCG. What is not stated in the Bill but I hope is implicit in all that the

Government have said is that there will be transparency in all this. Once you measure results, there is, ipso facto, an incentive to improve those results.

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The noble Lord, Lord Hunt of Kings Heath, asked me how a CCG can influence improvement in primary care when it is the board that is commissioning the primary care. I simply remind him that CCGs have a duty under the Bill to support the NHS Commissioning Board in its quality improvement functions with respect to primary care. Indeed, one of the key benefits of CCGs as we see it-and we know this from a practice-based commissioning which has been in place for a number of years-is the ability for peer review and peer pressure to drive up quality.

The noble Lords, Lord Harris and Lord Hunt, asked me who will lead the local strategies. Health and well-being boards will be the bodies that will produce a joint health and well-being strategy, and that will be designed precisely to address issues such as health inequalities, which involve different services working together. CCGs must have regard to these strategies in addition to reporting annually on health inequalities, as through the amendments in this group.

Lord Harris of Haringey: I just want to make sure that I understand the point that the Minister is making. Let us compare two localities in London. I mentioned Tottenham, so compare that with, say, the residents of Totteridge. They are very different socioeconomic groupings with very different health outcomes. What is the mechanism for addressing health inequalities between Tottenham and Totteridge? Who will be responsible for addressing inequalities between areas that are just a few miles apart but which have very different characteristics and very different social outcomes? The health and well-being boards are borough-based. Tottenham is in the London Borough of Haringey and Totteridge is in the London Borough of Barnet-neighbouring boroughs that are very different in composition. What will be the overarching structure that addresses those inequalities?

Earl Howe: Localism lies at the heart of our approach to these issues. Although I have no doubt that conversations and comparative analyses will take place between different health and well-being boards and different local authorities, in the end it is the responsibility of health and well-being boards to look to their catchments. As I said, the outcomes that are published, both in terms of the NHS performance and public health

and social care, will in themselves incentivise improvement, if the local authority and the health and well-being board work together as they should. This is a joint enterprise between public health, social care and the NHS.

We shall no doubt experience the effect of comparative work between local authorities once the early implementer groups have bedded down and begun their work. Both the board, however, and the Secretary of State will have duties in relation to inequalities. They overarch everything that happens and I suggest that that will ensure that a system-wide and strategic approach is taken, for example, through setting objectives in the board's mandate in relation to inequalities. These could feed down very easily to CCGs through commissioning guidance issued by the board. I hope that that gives the noble Lord a summary, or at least a flavour, of how we envisage this working.

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Lord Harris of Haringey: May I just clarify? Will there be nothing between the board at national level? Will it look right across the country and say, "We will address these inequalities"? Will there be nothing, for example, at the London level, to address inequalities between different parts of London or will it simply be driven nationally? That is a recipe for not necessarily making the best decisions in particular areas.

Earl Howe: The noble Lord will know, because the NHS Commissioning Board authority has published its proposals, that the board will be represented sectorally. There will be field forces in all parts of the country. My vision of this, and that of Sir David Nicholson is that in the areas in which the board operates it will take a view across a region and look at how outcomes vary between local authority areas. The board will be very powerfully placed to influence the kinds of inequalities that the noble Lord has spoken of. It is important for noble Lords to understand that the board will not be a collection of people sitting in Leeds. The majority of its staff will be a field force. I hope that that is helpful.

Lord Rea: Does the noble Lord accept that to smooth out inequalities costs money? Therefore, the CCG in Tottenham should get more per capita than the CCG in Totteridge. At the moment allocation is made according to an index that takes deprivation into account to some extent, but not enough. How will that be administered under the new system?

Earl Howe: The advisory committee for resource allocation which exists at the moment will advise on the allocation of resources according to a very detailed formula. That applies to the NHS and public health. There will be a separate ring-fenced budget that specifically takes account of deprivation. That budget will be held by Public Health England and passed down to local authorities to use at a local level. We are very clear that deprivation and health inequalities must be reflected in terms of the budgets that CCGs and local authorities receive. I hope that I can reassure the noble Lord on that point.

Government Amendments 68, 112 and 144 set out a requirement for the Secretary of State, the board and CCGs to report annually on their work to reduce health inequalities. We had a great deal of helpful and interesting discussion on reducing health inequalities in Committee and as a result of those discussions, we felt that it was important to bring forward three amendments on the reporting requirements. Amendment 144 requires the Secretary of State to include in his annual report an assessment of how effectively he has carried out these duties, meaning that Parliament will hold him to account. I have tabled parallel government Amendments 68 and 112, which require the commissioning board and CCGs to report on how effectively they have fulfilled their inequality duties. We believe that this will ensure that our objectives to reduce health inequalities and improve quality of care are embedded throughout the system from top to bottom. I hope that noble Lords can support those amendments when I move them.

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Baroness Morgan of Drefelin: I wonder whether the Minister could clarify something for me. I very much support the line of argument around the amendments. However, I am interested to know whether, if the Secretary of State has a duty to report back on the exercise of these duties, does that say anything about the importance of reporting on his other duties? Is a hierarchy being created? That is a point for clarification.

Earl Howe: There is no hierarchy but the Secretary of State will be bound to report to Parliament and, in doing so, he must show that he has exercised his functions in a way that fulfil his statutory duties under the Bill. Parliament will no doubt hold him to account for having done so. He must demonstrate across the piece that he has had regard to those duties.

Baroness Royall of Blaisdon: My Lords, I am grateful to the noble Earl, Lord Howe, for his reply, and for the support for my amendments around the Chamber. I have a couple of comments. First, in terms of quality standards, like the noble Baroness, Lady Finlay, I wonder about a GP's ability to fulfil his duties both as a clinician and a commissioner. Currently GPs often find diagnosis quite difficult and I am concerned about them having to commission as well as diagnose. If they do not fulfil their tasks as both clinicians and commissioners, the patients will suffer.

My noble friends Lord Hunt and Lord Harris asked who takes the leadership and responsibility for ensuring that quality standards are adhered to when they are brought forward by NICE. The Minister said that localism is one of the answers. I find that a frightening prospect rather than a reassuring one. I think it is a recipe for chaos rather than quality, but perhaps that is a personal view.

I pay huge tribute to NICE, which I think does excellent work, but I recognise that it is very stretched. It has immense burdens and responsibilities. I hope that this very short but excellent debate will be a catalyst for swifter action in terms of quality standards, but I recognise that there is always a balance to be struck between quality and speed. However, in five years, an awful lot of people can die while waiting for quality standards. Having said that, I am grateful to the Minister for his response, and I beg leave to withdraw the amendment.

Amendment 5A withdrawn.

Consideration on Report adjourned until not before 8.35 pm.

Sitting suspended.

Health and Social Care Bill

Report (1st Day) (Continued)

8.35 pm

Amendment 6

Moved by ***Lord Hennessy of Nympsfield***

6: After Clause 2, insert the following new Clause-

"The Secretary of State's duty as to the NHS Constitution

After section 1A of the National Health Service Act 2006 insert-

"1AA Duty as to NHS Constitution

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"(1) In exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution.

(2) In this Act, "NHS Constitution" has the same meaning as in Chapter 1 of Part 1 of the Health Act 2009 (see section 1 of that Act).""

Lord Hennessy of Nympsfield: I shall speak also to Amendment 150, which is in my name on the Marshalled List. These amendments are a product of the conversations chaired by my noble friend Lord Laming, designed to bring the highest possible level of consensus to what the noble Earl, Lord Howe, calls the suite of clauses dealing with the accountability of the Secretary of State. I am very grateful to my noble friend for his sensitive chairmanship of the discussions and to the Minister for generously accepting the argument-that the special essence of the National Health Service as distilled in the NHS constitution be enshrined in the Bill.

With this new status, the NHS constitution will shine even more, both as a beacon for all involved in healthcare, whatever their place in the proposed new mixed economy of service provision, and as a statement of enduring values, which occupy such a central place in how we wish our services to be undertaken and how we conceive of ourselves as a people.

I shall not detain your Lordships long, as I am confident that these amendments, for all the friction and division that other clauses have generated, are ones that embrace the views of the vast majority of your Lordships as they do the country they serve. But I must also express my gratitude to the noble Lord, Lord Darzi, and his colleagues in the last Labour Government, for commissioning the wide consultation whose streams of thought fed into the NHS constitution when it first appeared in January 2009. It managed to contain the key principles in seven well worded paragraphs, which I shall

not recite as your Lordships have the text to hand and will be familiar with its ingredients.

The Bill, when an Act, will take a great deal of bedding down, and it will take the second coming for the rifts between the political parties and the anxieties expressed by so many health professionals to be assuaged-and perhaps not even then. However, with the NHS constitution in its prominent place towards the top of the statute, we shall have a touchstone, not just for aspiration and inspiration but for behaviour and conduct, a shared talisman for the tougher moments when the implementation of this Bill throws up its inevitable problems and controversies. When we find a lustrous patch of consensus on the NHS's road from 1948, as represented by the NHS constitution, we should cherish it through thick and thin, for we are never better as a country than when we concentrate on those things that unite us rather than divide us. I beg to move.

Baroness Thornton: My Lords, I am very pleased to put my name to this amendment and I congratulate the noble Lord, Lord Hennessy, on his tact and diplomacy in getting us to this point, and in getting agreement to have the constitution mentioned in the Bill, and in such a prominent part of it. In preparing a few supportive remarks, I had a look at the constitution because I was working for my noble friend Lord Darzi in a similar

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role to the one the noble Baroness, Lady Northover, has-as his support and his Whip-when we were working towards the constitution, and when it was discussed and adopted across government and Parliament.

The importance of having it in the Bill is there in various key parts of the constitution, which are worth mentioning on the record here because we need to remember them as we move forward to discuss this Bill in all its glory in the next five or six weeks, or however long it takes us. The constitution says:

"The NHS is founded on a common set of principles and values that bind together the communities and people it serves-patients and public-and the staff who work for it".

It goes on to say that it,

> "establishes the principles and values of the NHS in England. It sets out rights ... and pledges which the NHS is committed to achieve".

It says:

"All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions".

That is a very important part of why this needs to be in the Bill.

The final part which I would like to draw to your Lordships' attention is point 6 of the guiding principles in the constitution, which is a commitment,

> "to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves".

That is exactly right. It is not the shareholders of companies and not individuals who might seek to make a profit but the people whom the NHS serves, and the taxpayer.

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, I am very grateful to the noble Lord, Lord Hennessy, for tabling these important amendments and for the eloquent way in which he introduced them. As he said, they seek to require the Secretary of State to have regard to the NHS constitution when exercising his functions in relation to the health service. I say to him in all sincerity that I very much welcome his contribution throughout this debate. I identify myself entirely with the enthusiastic remarks that he addressed towards the constitution itself, which is a most succinct and inspiring document, and I agree with him that we have reached a very workable and satisfactory outcome to the question that he originally posed to me and to the House.

I fully support these amendments. It is right that we continue our commitment to the principles set out in the NHS constitution. I hope that these amendments together provide noble Lords with reassurance of the Government's continued commitment to the core principles and values to which the noble Lord and the noble Baroness have referred. I commend them to the House.

Lord Hennessy of Nympsfield: I am grateful to the noble Baroness, Lady Thornton, and the noble Earl, Lord Howe, for their kind remarks. Earlier, a noble Lord-I forget who-thought we were mired in the treacle of consensus. All I can say is: long may we be stuck in this particular pot of treacle.

Amendment 6 agreed.

Clause 3 : The Secretary of State's duty as to reducing inequalities

Amendment 7

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

7: Clause 3, page 2, line 40, at end insert-

", and

(b) the Secretary of State should by regulations set out a clear system of recourse for patients, or other concerned individuals, who do not believe that an equitable service is being commissioned either for their condition or in their locality, or both."

Baroness Finlay of Llandaff: My Lords, the amendment seeks to ensure that there is a system of recourse for patients or other people who are concerned and who do not believe that an equitable service is being commissioned either for their condition or in their locality. One of the difficulties that patients have is to challenge decisions once they have been made without a prohibitively expensive legal challenge. As a result, many decisions are made by commissioners that are effectively unchallengeable, for example on service configurations where the public are not consulted properly or in fact feel that they have not been consulted at all.

Some clear system of recourse is required that will give patients a meaningful chance to challenge decisions that they think are wrong, poorly consulted on or inadequately evidence-based, or that might even have ignored the evidence that is there or the guidance that goes with it. In such an instance, a system of recourse would be to allow people to challenge where they believed that services had not been provided fairly or equitably. I expect that the Minister will say that there is always healthwatch and that they could go to their local one, but how is that loop closed? What are the powers to influence the commissioning decision? How are patients who feel that they have really not been provided with the service that they need able to appeal, be listened to or have a fair hearing? They may be refused or their points may be accepted, but that loop for patients needs to be closed and there need to be clear pathways.

8.45 pm

I fear that just saying that they can go and complain locally, or that they can go to their local healthwatch, is not going to be enough. They may find that they are in a long queue or in a complaints system that they find difficult. I hope that the Minister might respond that guidance and regulations will deal with this and will provide clear pathways for patients and others who wish to question decisions. I beg to move.

Lord Beecham: My Lords, I welcome the noble Baroness's amendment, particularly because it extends the implicit obligations under Clause 3 from the individual to the locality. It includes individual access, of course, but it speaks in terms of an equitable service being commissioned either for the individual patient's condition or in their locality, and that enhances to a considerable degree the provision of Clause 3 and its proposed

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amendment to the 2006 Act. The drafting of proposed new Section 1B is a little odd, it might be thought. The intention is clearly good, but,

> "have regard to the need to reduce inequalities between the people of England",

is a slightly curious phrase. It might be asked, between the people of England and what? The drafting could be improved by the time we get to-actually it will not, as we are on Report. Perhaps it is capable of being improved, let us say.

The noble Baroness has touched on the broader issue of the locality, which raises issues of how the Government might pursue their objectives, which are shared by all sides of the House. There are different organisations in the new structure that will have a responsibility to promote equality, which will include the clinical commissioning groups and the health and well-being boards. Some mechanism ought to provide accountability for both those bodies. In particular, the need to promote equal treatment in a patient-centred service ought to be very much part of the joint strategic needs assessment that should be undertaken by the health and well-being boards, and ought to influence the commissioning. We hope that these regulations will establish that connection and, as the noble Baroness has suggested, lay down a clear structure, though not one that is too prescriptive-a pathway, as she usefully put it, for patients, individually or, as it were, collectively, to raise the issues that concern them through healthwatch.

There is another route that I hope the noble Baroness will agree would be helpful. Local authorities retain the duty of scrutiny of local health services. For that matter, inequalities can arise on the social care side of the health and social care world. Local authorities therefore provide an additional route that would repay further consideration.

It ought to be feasible for a health and scrutiny committee, and I serve on one in my own authority, to have regard to the level and type of complaints regarding not only equitability but the standard of service in all parts of the health and social care services in that locality. Therefore, it would be useful if the Minister could liaise with the Local Government Association, perhaps to produce some kind of working model for dealing with this aspect. For example, it may be that the Centre for Public Scrutiny could, in conjunction with the department, the LGA and HealthWatch itself, representing patients, come up with a model that authorities could adopt and promote among their populations to provide clear recourse for dealing with difficulties and complaints about either individual treatment or collective provision that is a matter of local concern.

I hope the Minister will accept the thrust of the amendment and, even if it is not built into the Bill, that action can be taken to fulfil the aspirations that the noble Baroness has outlined.

Lord Willis of Knaresborough: My Lords, briefly, I should like some clarification on this amendment, and I hope that the Minister will be able to provide just that in summing up. There seems to be a real difficulty here. The architecture of the Bill says that we should have a Commissioning Board and local commissioning

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groups, and that those local commissioning groups will have a great deal of autonomy over the services that they commission-for example, the drug pathways that they permit-in treating particular patients. This amendment appears to say that if the treatment given through the commissioning pathway of one commissioning group is different from that of another commissioning group, you would therefore have recourse to action if you felt, for instance, that the drug regime in one group was unacceptable. Perhaps I could have clarification on that. It is important because there will be that sort of difference in provision, regardless of whether we agree to the local commissioning group position.

Lord Northbourne: My Lords, I intervene briefly to support the noble Baroness, Lady Finlay, because I believe that there will be real problems. The immense complexity of the Bill will lead to tremendous delays and a great deal of misunderstanding among people who feel, rightly or wrongly, that they have failed to get the service or treatment to which they are entitled. I hope the Minister can say something about the possibility of some sort of short-circuit response, whereby people who feel that they have been ill treated can, if necessary, have some kind of help and encouragement to make contact with the right people to resolve their problem.

Earl Howe: My Lords, this has been a very useful short debate. As the noble Baroness, Lady Finlay, said, her amendment seeks to provide appropriate recourse for individuals who believe that the commissioning of services for either their condition or their locality is inequitable. It would insert a new paragraph in the Secretary of State's inequality duties. The noble Baroness spoke with considerable persuasiveness on this amendment but I will suggest to her that it is unnecessary and explain why.

The Bill and existing legislation already provide a number of mechanisms for exactly the kind of recourse that the noble Baroness seeks. She foresaw that I would talk about local healthwatch and I will. Local healthwatch, which will replace local involvement networks from April 2013, will provide local people with the opportunity to have their views on their needs and experiences made known to commissioners and providers of health and social care services and others. One of the roles of local healthwatch will be to make reports and recommendations about how local care services could or ought to be improved. To ensure that these have real clout, the Bill requires the people who receive such reports and recommendations, such as the NHS Commissioning Board, to have regard to them in exercising any function relating to care services.

We then have a further avenue for recourse because HealthWatch England will also provide the NHS Commissioning Board, among others, with the views of people on their needs for, and experiences of, health and social care services and on the views of local healthwatch and others on the standard of provision of services and on whether or how the standard could or should be improved. Where the board is provided with advice, it must inform HealthWatch England of its response, or proposed response, to the advice.

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However, if an individual feels that a CCG, or the board, or any other body in the future health service, has neglected their responsibility with regard to tackling inequalities, they can do several things. They may raise the matter directly with the organisation itself, specifically by pursuing a complaint through the NHS complaints procedure. Where not satisfied with the response at a local level, they may refer the matter to the Health Service Ombudsman. As a last resort-I emphasise "last resort" because I do not want noble Lords to feel that this process would be run of the mill-as the NHS constitution makes clear, should an individual feel that local resolution has not been possible, and in the event that the Secretary of State or an NHS body is failing to comply with its legal

duties, there would be a right to seek legal redress by means of a claim for judicial review.

There is a central issue here. CCGs will be under a statutory obligation to arrange for provision of care to meet the reasonable requirements of the people for whom they have responsibility. The local authority's health and well-being board, the membership of which will include the CCG or CCGs, will assess local population needs, and will develop a strategy to meet those needs. Local healthwatch will also be a member of that board and be able to input into the strategy. There will be a duty on the CCG, the local authority and the NHS Commissioning Board to have regard to the relevant assessment and strategy when exercising functions. This would include the function of preparing commissioning plans. The NHS Commissioning Board will have a duty to perform an annual assessment of how well each CCG has fulfilled its duties in the previous financial year. This will include, in particular, an assessment of how well it has taken account of assessments and strategies under Section 116B of the Local Government and Public Involvement in Health Act 2007.

My noble friend Lord Willis rightly said that we should expect that there will be differences between CCGs in their commissioning policies. Of course he is right, because each CCG will be bound to formulate policies for commissioning that reflect the needs of their constituent populations. I do not think that we should shy away from variation that is considered and that genuinely reflects that diversity in population. What we do not want, clearly, is postcode and random variations which have no relationship to the needs and requirements of local patients.

We should not forget either that the Health Service Commissioner has power to investigate complaints that are not resolved locally and to make recommendations as a result of those investigations. It is very rare for those recommendations not to be implemented but, in extremis-and this is not often done-the Health Service Commissioner is able to lay a report before Parliament.

We believe, therefore, that there is already a clear system of recourse where patients are concerned that an equitable service is not being commissioned either for their condition or their locality, and the Bill strengthens the ability of patients to make their views heard. The Bill also introduces, for the first time ever, duties on the Secretary of State and commissioners to have

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regard to the need to reduce inequalities, and amendments we have tabled would ensure that they would have to report on how they had fulfilled those duties.

With those remarks in the round, I hope that the noble Baroness is perhaps more reassured than she was at the outset of the debate, and that she will be willing to withdraw the amendment.

9 pm

Baroness Jolly: Before the Minister sits down, will he clarify whether the same processes that he has just outlined would apply to people in receipt of specialist services that are commissioned by the NHS Commissioning Board, not by local CCGs?

Earl Howe: My Lords, where a service is commissioned by the NHS Commissioning Board-and let us imagine that it is a specialised service-the patient's recourse should be to the board. However, of course, the board will be represented at a local level rather than only centrally, and we expect that the board will be represented in health and well-being boards and in the discussions that take place there. It would therefore be possible for a patient to address their concerns, in the first instance, to the health and well-being board, which would have the ability and power to communicate directly with the NHS Commissioning Board, if that was felt to be appropriate. However, as I said, the patient would be able to go straight to the board in those circumstances.

Lord Harris of Haringey: I appreciate that this is very bad manners, given that I missed most of the debate. The Minister has just said-although perhaps I misinterpreted him-that the NHS Commissioning Board will have a representative on every local health and well-being board. If so, how will those individuals be known or accountable? Is that not the most extraordinary bureaucracy? He seems to have made a most extraordinary statement.

Earl Howe: My Lords, we are at Report stage and I hope that the noble Lord will forgive me if I do not reply at length. The point I was seeking to make was not about representation on the board but involvement in the health and well-being board's wider deliberations. It is entirely open to a health and well-being board to invite a member of the Commissioning Board to be a permanent member, but I am not saying that we are prescribing that.

Baroness Finlay of Llandaff: Perhaps I may seek a tiny bit of clarification. The noble Earl spoke about the ombudsman as being almost a final port of call. Will the Minister confirm that the ombudsman would have the ability to investigate any organisation that is providing services to patients if it is in receipt of any NHS money whatever-not only if the care for an individual patient is commissioned from it but if it is receiving a block grant? In particular, I have in mind services such as those provided by hospices that may be receiving a block grant but do not have a specified contract per patient, and it may

be that its patients want to question what is going on or that they have a concern that they wish to express and take further. Apart from the local complaints service within the

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organisation, it is really important that such patients have the same ability as other patients to have oversight through the ombudsman. I know that we have discussed this previously, and I am seeking clarification today on that issue.

Earl Howe: The answer to the noble Baroness is that all NHS-funded care would come under the umbrella of the ombudsman. It is not about organisations; it is about whether that person is or is not an NHS patient and about the care that they are receiving as an NHS patient.

Baroness Finlay of Llandaff: This is Report; I do not want to and fro. I will assume that that covers part-funding of care by charities as well as where care is fully funded by the NHS, so the same will apply.

I am grateful to the Minister for setting out the processes so clearly. It will be very helpful for patients, patient groups and charities in particular to see that laid out. For clarification, of course there will be local variation, different drug regimes and different ways of doing things. Equipoise is around the evidence base. The problem is where there is no provision or gross differences. That is where patient groups are concerned. I beg leave to withdraw the amendment.

Amendment 7 withdrawn.

Clause 4: The Secretary of State's duty as to promoting autonomy

Amendment 8

Moved by ***Earl Howe***

8: Clause 4, page 3, line 5, leave out from "must" to end of line 6 and insert "have regard to the desirability of securing, so far as consistent with the interests of the health service-"

Earl Howe: My Lords, I shall speak also to Amendments 9, 34, 53 and 54.

This group of amendments deals with the role of the Secretary of State in the health system. As noble Lords will be aware, our proposals for the NHS involve a fundamental

shift in the balance of power away from politicians to patients themselves and to doctors and other professionals. Greater local autonomy is one of the key things that will enable local front-line services to become more responsive and innovative, in turn delivering greater efficiency and quality. The Bill makes clear that Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies in the system-backed by extensive powers of intervention in the event of significant failure.

The amendments we are debating here cover some of the key concerns raised by the Constitution Committee and Peers from across the House, as part of our wider discussions about ministerial accountability. These are the autonomy duties on the Secretary of State and the Commissioning Board and the link between the functions of clinical commissioning groups and the Secretary of State's duty to promote the comprehensive health

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service. I will speak to each of the amendments tabled in my name, as well as the amendments tabled by the noble Baroness, Lady Thornton, which seek to remove the duties of autonomy on the NHS Commissioning Board and the Secretary of State.

Amendments 8 to 10 and 52 to 54 concern the autonomy duties placed on the Secretary of State and the board. Government Amendments 8 and 53 re-phrase the duties of autonomy on the Secretary of State and the Commissioning Board as duties to,

> "have regard to the desirability of",

autonomy, rather than duties to,

> "act with a view to securing",

such autonomy. The desirability of autonomy is therefore a factor for the Secretary of State and the board to consider when exercising their functions, rather than an end which they must seek to secure or promote. That should allay the fears of those who felt that the autonomy duties would prevent Ministers and the board intervening when they needed to.

In addition, changing to a duty to have regard necessarily means that the autonomy duties are subsidiary to the primary duties of the Secretary of State in Section 1 of the NHS Act: to promote the health service and to exercise his functions so as to secure the provision of services. To that extent, there is no further need to state that the duties of

autonomy are "subject to" his Section 1 duties. However, government Amendments 9 and 54 make a further change to address this point. Rather than simply say that the autonomy duty is "subject to" the duty of promoting the comprehensive health service, they set out an explicit test, which makes clear that promoting the health service and securing the provision of services takes priority over autonomy, if there is ever a conflict between the duties. We think that this more clearly indicates how the Secretary of State and the board should resolve any tension between autonomy and the interests of the health service. I hope that noble Lords will agree that this provides helpful clarity and avoids any possible doubt.

Having said that I would address the amendments of the noble Baroness, Lady Thornton, I think that on reflection it would be discourteous of me to do so before she has introduced them. I shall therefore retain my remarks for later in the debate if she chooses to speak to those amendments. Meanwhile, I beg to move.

Lord Marks of Henley-on-Thames: My Lords, perhaps I may explain why I support the Government's amendments on the autonomy clauses to which I have added my name-that is, Amendments 8, 9, 53 and 54.

The autonomy clauses were at the heart of the Government's consultation with other noble Lords about the Secretary of State's duties. During Committee and thereafter, at the very helpful discussions that we have had with my noble friend the Minister and with Peers across the House and, indeed, at the meeting of lawyers in which I took part with my noble and learned friend Lord Mackay, the noble and learned Baroness, Lady Scotland, and the lawyer advising your Lordships' Constitution Committee, a substantial consensus was reached.

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The concerns that we sought to address, which I regarded then and still regard as significant, were twofold. The first was that I believed there would be an inherent conflict between, on the one hand, the Secretary of State's duties under Clause 1 to promote a comprehensive health service and to exercise his functions so as to secure services and, on the other hand, an unfettered duty to promote the autonomy of others. Secondly, if the Bill went unamended, there would exist a risk that a Secretary of State who was unwilling to intervene when things went wrong would be handed a justification for inaction. Such a hands-off Secretary of State could say, "I will not intervene because I am

bound by my duty to promote autonomy". In my view, with the Bill as it stands it would be very difficult to mount a successful legal challenge to such a failure to intervene.

Those were the two flaws in the Bill that the amendments were required to address. In relation to the board, the unamended Bill was flawed in exactly the same way as it is in relation to the Secretary of State.

The consultations that we held outside the Chamber during Committee led to the formulation of the Government's amendments. As the Minister has pointed out, the effect of Amendments 8 and 53 is that the duty to act with a view to securing autonomy is reduced to a duty to have regard to the desirability of securing it. That is still subject to the limitation that the duty applies only so far as it is consistent with the interests of the health service. Therefore, what is currently an absolute duty to follow the autonomy line is to be replaced with a more nuanced and, I suggest, a more appropriate obligation to accord to the desirability of autonomy its proper place in the balancing exercise which all discretionary decision-making involves.

However, it is Amendments 9 and 54 that are decisive in addressing the concerns that we identified. Those two amendments provide that in the case of conflict between the Secretary of State's or the board's duties in relation to autonomy and their overarching duties under Clause 1 or the board's overarching duties to secure the provision of services, those overarching duties will prevail. Those four amendments taken together fully address the two flaws of which I spoke and, I suggest, completely resolve the issues that they pose.

I turn now to the two amendments of the noble Baroness, Lady Thornton, directed at deleting the two autonomy clauses. Indeed, at the earlier stages of this process, I believed that the autonomy clauses could and should be deleted from the Bill. However, my view now is that with the problems that they presented having been addressed, we should support the government amendments and retain the two clauses as amended. Promoting autonomy is, in principle, to be welcomed as many who have spoken from all sides of the House both on Second Reading and in Committee have stressed. It is fundamental to the architecture of the Bill, and its great merit that it establishes a clear, decentralised structure for the health service. It is entirely welcome that future commissioning decisions, in particular, will be made locally to meet local needs, locally assessed.

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9.15 pm

A number of Peers have spoken of the need to avoid micromanagement and of the desirability of expressing that in the Bill. There was much discussion as to whether micromanagement was a word that could be usefully employed in legislation. The Government's amendments maintain the commitment to avoiding micromanagement but do so in a way in which the flaws in the unamended Bill are rectified. I suggest that they represent an elegant and effective solution to a difficult and challenging problem. I believe that the way in which this solution has been reached brings great credit to this House, as others have said today. I should like to say how much I have personally appreciated the opportunity to work with my noble friend the Minister, and officials and draftsmen from his department, as well as other Peers from across the House who have all brought us to this compromise. These are amendments that we can support and not lose the commitment to avoiding micromanagement. That would disappear if we accepted the amendments tabled by the noble Baroness, Lady Thornton, so we should oppose them.

I briefly express support for Amendments 34 and 35, which neatly tie in the CCGs into the Secretary of State's duty under Clause 1 and the objectives and requirements stipulated by the Secretary of State for the board. In that way, the line of responsibility from the Secretary of State through the board to the clinical commissioning groups exercised through the mandate is maintained and clarified. This has been very important because the amendments embed the mandate in the line of responsibility by which the Secretary of State exercises his constitutional responsibility for the provision of the health service. It is also consistent with the new arrangements for provision introduced by the Bill.

This establishment of responsibilities was something that we were very concerned to see in the Bill. Again, it is a tribute to the House that the procedures we adopted have achieved a structure that is both clear and internally consistent, while being effectively co-ordinated.

Baroness Jay of Paddington: My Lords, the House will be aware that the second report of the Constitution Committee on this Bill suggested amendments in this area, precisely for the reasons well outlined by the noble Lord, Lord Marks, and as expressed by the Minister. We were concerned that the way in which the Bill was originally framed would dilute that line of responsibility through the Secretary of State and that the provisions on autonomy were such that that link would be broken, or at least threatened.

I wish to explain briefly why, although the committee produced amendments that are very similar to the ones tabled by the Government and supported by the noble Lord, Lord Marks, I have not put my name to them. That is simply because the wording of the government amendment is not as simple as the one that the Constitution Committee supported and wished to see in the Bill. We suggested:

"Subject to sections 1(1) and 1(3)",

which we discussed on government Amendment 5,

> "and so far as is consistent with the interests of the health service, the Secretary of State must, in exercising functions in relation to that service, have regard to the desirability of securing",

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et cetera. Clearly that is very close to the wording of the amendment tabled by the Government. The Constitution Committee is particularly grateful for the phrase "having regard to", as the Minister has explained. We were not in a position to discuss the change in formulation that has occurred, and we have yet to listen to my noble friend Lady Thornton, but as there were members of the committee who, like me, would prefer to see this clause deleted, I have not put my name to this amendment although I understand that it is very close to the one that the committee originally suggested.

Baroness Finlay of Llandaff: My Lords, I wish to raise some questions because I have put my name to the amendment suggesting that Clause 4 be deleted. The Government's guidance notes published with the amendment that has been tabled appear to make the duty of autonomy subject to the Secretary of State, but there is ongoing concern that there remains the risk that the clause could be used by clinical commissioning groups to justify not providing a full range of services or putting inappropriate services out to tender. While local organisations should have the freedom to respond appropriately to the health needs of the population, local commissioners should not be able to act totally autonomously and commissioners must have regard to national guidance. In his closing summary, the counsel to the chair in the Francis inquiry pointed out that there is a need for far greater standardisation of operating and quality standards in the NHS and close monitoring of compliance.

Concern about the inclusion of Clause 4 continues to lead to some uncertainty, confusion and concern about how competition would be applied in the new system. Phase 2 of the Future Forum recommended that the Government clarify the rules on choice, competition and integration. The concern is that if the restraint on autonomy is not as tight as it possibly ought to be, services could fragment. The Government need to clarify that integration will trump competition. I ask the Minister to clarify that the national Commissioning Board will be prepared to intervene if clinicians feel that the type of competition that is being proposed could fragment services. We have heard quite a lot about commissioning along whole-care pathways, such as musculoskeletal services and mental health services, and in whole-function areas, such as community services. There is concern that where this has happened in the east of England with musculoskeletal and respiratory pathways, there is a sense that they should have been put out to tender more than they have been. There is concern that there are times when whole-care pathways should not be subject to competition. The difficulty with the clause is that it leaves in doubt how much integrated whole-care pathways, which may not leave complete autonomy to different parts of the system, will trump competition between different parts of the system.

Lord Warner: My Lords, I had not intended to intervene in this group of amendments, but I want to make a couple of points and leave a question with the Minister. I have always been in the camp that feels that

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Clause 4 was misguided and should be abandoned. I can see the case, which was put very well by the noble Lord, Lord Marks, for retaining Clause 4 with these more controlled features. Listening to this debate, I have a number of concerns.

There is genuine concern that there might be a really rogue clinical commissioning group, but listening to the noble Baroness, Lady Finlay, has revived my concern that somewhere along the line, if we are not very careful and are too controlling, we will stop the initiatives that we want from commissioners as the NHS faces considerable challenges. As the House knows, I do not have the same fear that other Members of your Lordships' House have about third-sector or independent-sector providers, so I would not want anything in the peace that we see breaking out here to inhibit creative clinical commissioning groups setting off on new paths for new types of services simply because major people in the NHS have not woken up to the need for significant change. I hope that the Minister can reassure me that, in accepting this more nuanced version of Clause 4 on autonomy, we are not really inhibiting the creativity of clinical

commissioning groups to bring in new players, even if it may seem a rather radical idea when they start to do it.

Finally, as the Minister knows, I have a mild obsession with the whole issue of a pre-failure provision in this legislation, which we will come to later. One of my continuing concerns is that we do not want to end up with a situation where we are restricting the ability of the National Commissioning Board to begin to intervene-to tackle failure at the local level-simply because autonomy requires people to flounder along as long as they like on the grounds that it is all about localism. I hope the nuanced version of Clause 4 that we are getting is still accepted as something that would enable the National Commissioning Board to intervene when there was a total failure by providers and commissioners at the local level to tackle the problems of clinical and financial unsustainability.

Lord Harris of Haringey: My Lords, every time I look at Clause 4-[*Laughter.*] I cannot understand what my noble friends find so amusing, but every time I look at this particular clause-if that makes it easier for them-and particularly listening to the remarks of the noble Lord, Lord Marks of Henley-on-Thames, I have been confused as to what problem the Government think they are solving by the clauses on autonomy.

There is apparently a concern about micromanagement. There is a desire to have local innovation, flexibility and local responsiveness. What is it about the current arrangements in the NHS that necessarily prevents local innovation, flexibility and local responsiveness? Why are we having these discussions? If there is a concern from the Government that they are micromanaging, they have a solution-they stop micromanaging. Again, what are we trying to do here?

However, once you include,

> "the desirability of securing, so far as consistent with the interests of the health service"-

or whatever form of words you choose to have-this principle of autonomy, you are setting up an automatic

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conflict. If the form of words that the Minister and the noble Lord, Lord Marks of Henley-on-Thames, have put their names to was in the Bill, does this mean that the Secretary of State will be intervening when there are clear cases of postcode lottery? That presumably is the implication. Or is the Secretary of State now going to say that in

fact a postcode lottery is what this legislation is designed to create? We should be clear what these clauses are trying to prevent. What is the problem that they are trying to solve?

The noble Lord, Lord Marks of Henley-on-Thames, was moving in his description of how the Secretary of State would weigh these difficult issues of the possible conflict between,

> "the desirability of securing, so far as consistent with the interests of the health service",

autonomy and the priorities of the fundamental role of the NHS. This is a balance that has to be weighed. He talked about this line of accountability that will exist between the NHS Commissioning Board and the CCGs-these tentacles that the NHS Commissioning Board will put throughout the NHS. They will be unaccountable and anonymous, and individuals will be operating at regional or at local level.

There will be an army of people operating as the tentacles of the NHS Commissioning Board. They will be informing the Secretary of State so that he can exercise his judgments about the balance between autonomy and meeting the principles of the NHS. I wonder whether the Secretary of State is creating the most extraordinary bureaucratic monster to solve a problem that could be easily solved simply by resisting his tendency to micromanage.

9.30 pm

Baroness Jolly: My Lords, I support the government amendments in this group, which are also in the name of my noble friend Lord Marks. They represent the last in a suite of 10 amendments which came out of the process so eloquently described by many noble Lords in earlier debates today, and which take us from the Secretary of State right through the board to CCGs, accountability and micromanagement, tentacles and all.

Like everyone else I should like to state my thanks, and on my Benches there are two people to whom I owe particular thanks. My noble friends Lady Williams and Lord Marks worked very hard from last March to make this happen. In association with many others, including my noble and learned friend Lord Mackay of Clashfern and the noble Lord, Lord Hennessy, who is no longer in his place, they worked extremely hard at getting these amendments together. I hope that the noble Lord feels comfortable and confident about the expression he used in Committee about the DNA of NHS Bills, and that he feels that that DNA is now weaving through this suite of amendments-from the 1940s to the 21st century. The noble Baroness, Lady Jay of Paddington, and the Constitution

Committee played such a vital role, and my noble friend the Minister smoothed the way. As I say, however, I thank in particular my noble friends Lady Williams and Lord Marks.

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Baroness Thornton: My Lords, when we were having our negotiations on this part-on which I was very happy to take part, even if I was regarded on some issues more as grit in the oyster than as co-operative help-they were about these issues, including autonomy. I have not changed my view. I shall speak to Amendments 10, 36 and 52.

We have no problem with the concept of autonomy. In principle our position is that autonomy has to be earned, and that it should be able to be taken away as well. That formed the principle and the basis on which the foundation trusts were established. However, we part company with the Government on their view of autonomy, and we are not completely convinced by the point made by the noble Lord, Lord Marks of Henley-on-Thames. On first sight of the Bill it seemed that autonomy was to be presumed and that each part of the service would be subject to less interference from the other parts in a way which could be detrimental. There would therefore be less performance management, and giving various bodies more powers with less need to sign off an agreement could mean that there would be less co-operation. Bodies acting in their own interests via a market process will mean that the motivation could be something that does not have the NHS and patients at its heart, and that there is less planning and system management, which sometimes actually is required. That is how you deal with things like postcode lotteries. You have to collect the information, compare it between different parts of the country experiencing different levels of deprivation, and then you have to take decisions which are about planning how to use your resources to ensure that people are not disadvantaged. So there are some very good reasons why planning and systems need to be in place.

The original briefing on the Bill stated that CCGs would not have PCTs or SHAs above them to performance manage them and that the commissioning bodies were not meant to performance manage but only to step in if there was a danger of failure. Again, that was the original briefing. It is not surprising that when we first discussed this in Committee there was general agreement across the House that the Bill would be better off without Clause 4 and what was then Clause 10 but is now Clause 12.

Since then the Constitution Committee has done what I think is really rather a good job. Although I was not deliriously happy about it, I was prepared to live with the draft produced by the committee. However, I do have problems with the draft that the noble Lord, Lord Marks, and the Minister have brought to the House. The provisions are not strong enough and some of the dangers that we originally expressed about problems with the autonomy clauses still exist. Furthermore, I take very much to heart the questions that both of my noble friends have raised. From different points of view they have asked pertinent questions and shown up the problems with the autonomy clauses. That is why, certainly in the process of our negotiations on Clause 4, I reserved my position to come to the House and explore whether what we actually wanted to do was delete it completely at this stage. On Clause 12, for the sake of consistency we feel that it should also be deleted. However, I have to say

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that because of the amendments that were accepted in the process of our negotiations, we feel less strongly about it.

I am not any more convinced as a result of this debate that our original position is not the right one-that if we cannot have the Constitution Committee's version of Clause 4, we should delete the whole clause. Obviously I will listen to the Minister's summing up of the debate, but at the moment I remain convinced that our position is indeed the correct one.

Earl Howe: My Lords, the noble Baroness, Lady Thornton, has spoken to Amendments 10 and 52, which, as she has said, would remove altogether the autonomy duties on the Secretary of State and the board. The noble Lord, Lord Harris, asked me what the problem is that the Bill is trying to solve in this regard. The duty is intended to promote a culture of fostering local autonomy rather than to outlaw specific practices; but without a focus on autonomy, it is possible that the mandate from the Secretary of State to the board or the framework document from the board to CCGs could impose disproportionately burdensome requirements on the system. The Government believe that local operational autonomy is essential to enable the health service to improve the outcomes of care for patients, provided that autonomy is within the framework of clear ministerial accountability.

The noble Baroness will be aware, because I have said it before, that we are aiming to free those closest to services to take decisions that are right for patients, free from central micromanagement by either the Department of Health or the NHS Commissioning Board. The amended duties, with the caveat that the interests of the

health service take priority, achieve the right balance between autonomy and accountability. Without the clause, a future Secretary of State could choose to ignore one of the fundamental principles of the Bill, which is that those closest to patients are best placed to take clinical decisions. Without the clause, a future Secretary of State would be free to use his extensive powers to micromanage the NHS. The autonomy duty is a necessary part of the Bill, placing a duty on the Secretary of State to consider the expertise of those in the health service while recognising that there will be circumstances-

Lord Harris of Haringey: My Lords, the noble Earl seems to be saying that you cannot trust your own Secretary of State not to micromanage unless they are effectively forbidden from doing so. We have all talked of the Secretary of State's accountability to Parliament. Surely the principle is that an accountable Secretary of State will be under enormous pressure from Parliament not to micromanage. If it is such a central issue of policy, Secretaries of State should simply be told not to do it, rather than requiring an Act of Parliament.

Earl Howe: I challenge the noble Lord to think of one Secretary of State, with the distinguished exception of my right honourable friend Mr Lansley, who has not succumbed to the temptation of micromanaging the NHS. No Secretary of State has been able to resist

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that temptation because, frankly, Parliament expects them to do it. That is what the system has expected of the Secretary of State. This is a burden on commissioners and clinicians, and, in the end, it does not well serve the interests of patients. It is all very well for the noble Lord to say, "Well, just stop", but the system encourages it and the duties on the Secretary of State are there to encourage it.

Baroness Thornton: I cannot resist saying that the noble Earl's right honourable friend Mr Lansley has dabbled and intervened on at least 12 occasions since the Bill started. He is on the record as saying on one of those occasions that certain managers should be sacked. Is the noble Earl saying that that will cease when this Bill is on the statute book?

Earl Howe: I am saying that the Secretary of State will not have the ability to micromanage the health service as he does at the moment. Whether the examples cited by the noble Baroness constitute micromanagement, if my right honourable friend is just expressing a view, I rather question.

The autonomy duty is a necessary part of the Bill because it places a duty on the Secretary of State to consider the expertise of those in the health service while recognising that there will be circumstances in which they must be able to step in to protect the interests of health service patients. That is the balance that we are trying to strike.

The noble Baroness, Lady Finlay, asked whether the autonomy duty would allow a clinical commissioning group to justify not commissioning the full range of services. The autonomy duty does not apply to CCGs; it is a requirement on the board and the Secretary of State. If a CCG chooses not to commission services and the board considers that this is not consistent with the interests of the health service, the board can intervene to direct a CCG. If the board fails to intervene when necessary, the Secretary of State has power to intervene. Finally, the Secretary of State can set out services which CCGs must commission, and he can do that in the standing rules if he considers it necessary. The CCG's key duty is to arrange services as it considers necessary to meet all reasonable requirements of the population that it is responsible for, and the amendments do not change that in the slightest.

9.45 pm

It might be helpful to say a little more about Amendment 34. I rather skirted over it in my introductory remarks, although my noble friend Lord Marks spoke to it very eloquently. We have tabled Amendment 34 to make clear the link between what CCGs do and what the Secretary of State does in the exercise of his functions. CCGs will be required to act consistently with the discharge by the Secretary of State of his duty under Section 1(1) of the National Health Service Act when exercising their duty to commission services under Section 3. Our amendment goes even further by requiring CCGs to act consistently with two additional things: first, the discharge by the board of its duty to promote a comprehensive health service; and, secondly, the objectives and requirements of the Secretary of State's mandate to the board. This addresses concerns raised by several noble Lords, including my noble

friend Lord Marks, who rightly said that there should be a clear link between CCGs and the mandate. The amendment also applies this duty to the powers of clinical commissioning groups to commission services under Section 3A, as well as their duty under Section 3, so that it covers all the NHS services that they commission.

The amendment does not mean that it is for an individual clinical commissioning group to determine how best to promote the comprehensive health service and then act

consistently with that view. On the contrary, the Secretary of State remains responsible for determining how best to discharge his duty to promote-in part through the mandate to the board but also through the exercise of his other functions. The clinical commissioning group must then act consistently with how the Secretary of State performs that duty. When making decisions about the commissioning of services-for example, when deciding whether to withdraw that service-a clinical commissioning group would have to bear the Secretary of State's duty in mind and act consistently with how he is performing that duty. To take a practical example, it would not be consistent for a clinical commissioning group to withdraw a service if the Secretary of State had indicated that the service was a vital part of the NHS that should be available to all patients throughout England.

The noble Baroness suggested that the duty of autonomy threatens care pathways. I simply cannot agree with her. As I have set out extensively on previous occasions, both integration and competition are tools at the disposal of commissioners to deliver high-quality care to patients. The autonomy duty would not alter that in the slightest.

The noble Lord, Lord Warner, asked whether what we are doing here would somehow inhibit CCGs from bringing in new players. No: where commissioners believe that new providers would serve the interests of patients, they will have the ability to bring in such new providers. Nor does it interfere in the slightest with the ability of the board to support CCGs in the event of distress.

I hope I have covered the questions that have been asked. I thank noble Lords for their valuable contribution to this debate. Once again, I thank the noble Baroness, Lady Jay, for her good offices in bringing us to this point. I hope that my remarks and the amendments tabled will reassure noble Lords that the interests of the health service are and always will be at the heart of the Bill.

Baroness Jay of Paddington: The noble Lord may be surprised to hear me ask this question because, as he kindly said, I have been very determined that the provisions on accountability and parliamentary responsibility et cetera should be strengthened in the Bill. However, I listened to what my noble friend Lord Harris said about what he described as the "increasing tentacles" of these links between the various providers and the Secretary of State. Is the Minister not becoming concerned-as I would in his position-that all this new accountability and these links undermine the basic policy positions of the Bill? That is why, for example, my noble friend Lady Thornton suggested that it would be cleaner-if that is the word-to remove the whole of Clause 4 from the Bill. The

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complexities that are being set up and strengthened, as the Minister has agreed, make the whole thing so incredibly complicated and bureaucratic that the underlying policy positions are being totally distorted.

Earl Howe: I do not share that view at all. I do not think that the autonomy and accountability arrangements are as complex as the noble Baroness seems to suggest. Autonomy and accountability are two sides of the same coin; one confers autonomy in exchange for accountability. That is the model that we have adopted and the one that I would hope that Parliament would wish us to adopt, given that substantial sums of public money will be at the disposal of commissioners throughout the NHS. I therefore do not see that the metaphor of tentacles employed by the noble Lord, Lord Harris, is actually very appropriate. It implies that there is an organisation holding those in the health service in a grip. That will not be the case. The role of the board is to support local commissioners; it is to be there as a resource to promote guidance, supported by the quality standards that we were debating earlier. It is not-I repeat not-a replica of the kind of line management that the NHS has seen to date.

Amendment 8 agreed.

Amendment 9

Moved by ***Earl Howe***

9: Clause 4, page 3, line 11, at end insert-

"( ) If, in the case of any exercise of functions, the Secretary of State considers that there is a conflict between the matters mentioned in subsection (1) and the discharge by the Secretary of State of the duties under section 1, the Secretary of State must give priority to the duties under that section.""

Amendment 9 agreed.

Amendment 10 not moved.

Clause 5 : The Secretary of State's duty as to research

Amendment 11

Moved by ***Earl Howe***

11: Clause 5, page 3, line 16, leave out "have regard to the need to"

Earl Howe: My Lords, we come to an issue that exercised us on more than one occasion in Committee-the issue of health-related research and the use of research evidence in the health service. My noble friend Lord Willis and others urged me to look again at the Bill's drafting, having expressed a concern that there was a need to strengthen the duties on the Secretary of State, the NHS Commissioning Board and CCGs to promote research, and the use in the health service of evidence obtained from research when exercising their functions.

Government Amendments 11, 60 and 103 are a response to that concern, and I hope that they will be welcome. The Government are absolutely committed to promoting research throughout the health service. By tightening the wording around the duties, we believe that the amendments send a powerful signal of that commitment. I beg to move.

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Lord Willis of Knaresborough: My Lords, it is a very pleasant duty to know that amendments proposed in Committee have been accepted by the Government in their totality. I thank the Minister for doing that. Amendment 11 removes from the Secretary of State the idea of "having regard to the need to", and gives a clear duty to promote research-and that is the case in Amendment 60, with commissioning boards, and in Amendment 103, with the local commissioning groups.

The broader research community-from the Wellcome Trust; the Academy of Medical Sciences; and members of the organisation that I chair and declare an interest in, the Association of Medical Research Charities-is incredibly grateful to the Minister for persuading his colleague, the Secretary of State, to accept far stronger policy on the duty to research. I also put on record my thanks to noble Lords on all sides of the House, including Cross-Benchers and Front-Benchers, for supporting this. It is very rare that you get such an area, which will clearly make a fundamental difference to patients, bringing the latest research to the bedside as quickly as possible-and to get the whole House to support that.

The result of this, if we make it work, will be the only research-led health service in the world. That is an incredible achievement in your Lordships' House and in many ways surpasses some of the debates that we have had about other areas, which frankly will not make a great deal of difference. I include the debate on Clause 4, which we have just

had. I know that Members on the Labour Benches like debating Clause 4; it gives them a feeling of déjà vu. However, in reality, for us as a nation to say that we have a research-led health service, where we can bring our huge clinical research base very quickly to patients, gives us an opportunity not only to deliver wonderful healthcare but to use that as an economic generator right across the world, and to bring high-quality healthcare to people who desperately need it. In fact, they need it a great deal more than we do.

In order for that to work and for these to be more than simply words in a Bill or rhetoric in this House, there have to be mechanisms to ensure that the duty which we have now agreed for the Secretary of State-or which I hope we will agree-concerned with the commissioning board and the commissioning groups, is actually brought to bear. There is nothing left in the Bill which gives me the comfort of saying that is going to happen.

We asked in Committee whether the commissioning board, and indeed the commissioning groups, should have to include in their commissioning plans what activity is taking place in research. If we get the health research authority up and running-I commend the Minister for all that he has done in terms of the special health authority-and if we start to get the 70-day permissions for clinical trials in, we will have a Rolls-Royce system, if I may use that analogy, for bringing research programmes right through into our hospitals for our patient development. However, unless we are able to have that built into the commissioning plans, and unless the commissioning board and the Secretary of State drive that-and this House and another place hold him accountable for that duty-quite frankly, it will be a hollow gesture.

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We also sought in Committee a requirement to report on that activity. How telling it would be if patients asked the commissioning groups or their local GP, "What is the activity in the cause that I have?"? We had that wonderful debate earlier on prostate cancer. That is the way in which we will get research developments brought into the clinics and into GPs: by patients being able to query what is happening in research. In thanking my noble friend the Minister, I ask him whether, in responding to this short debate, he will outline to the House very clearly how we are going to make this work. How will we make that duty to promote research into having an NHS that is world-class in terms of its research? How will it work?

Lord Warner: My Lords, I intervene briefly to echo everything that the noble Lord, Lord Willis, has said. We should not rest on our laurels as regards research. I do not want to go over the ground of micromanagement, but the NHS is very quick indeed to forget its responsibilities on research-and I say this as a Minister who was responsible for NHS research and development under the previous Government. We do not want to go back over the micromanagement debate, but the mandate is a critical issue if the NHS is really to keep research at the forefront of its thinking.

That is because at local level, too often on the provider side of the NHS research is forgotten. It is a Cinderella service which comes second to service delivery, and we end up seeing that people at senior levels and at local level absolve their responsibilities in this area. Nothing is a better example of that than the way in which local ethics committees and the people around them have inhibited the advance and the speedy development of research. I do not think that the Secretary of State can absolve himself of these responsibilities here with just this duty. Year in, year out, he will have to use the standing rules and the mandate to make sure that the NHS's nose is kept to the research grindstone in the very way that the noble Lord, Lord Willis, has said. I hope that the Minister will be able to convey some of that back in the department as well as on the Floor of the House.

10 pm

Lord Patel: My Lords, my name was on many of the amendments of the noble Lord, Lord Willis of Knaresborough, in Committee about promoting research. As someone who has been involved in or trying to do clinical research for many years-I declare an interest as a member of the council of the Medical Research Council-I commend the Government and welcome the amendments. They open up the possibility for commissioning groups to promote research in many ways, such as promoting clinical trials and encouraging the development of tissue banks, proper bioinformatics and proper audit and record-keeping. That will open up the field of stem cell therapy, bioinformatics, regenerative medicine and genomics, which will be very good for the NHS.

Baroness Morgan of Drefelin: My Lords, I, too, put my name to the amendments in Committee that have helped to precipitate this very welcome government

amendment and the support of the Minister. I do not want to repeat what has already been said but I want to make one point: we in the House of Lords have worked hard to promote the importance of research in the NHS, and we will take a strong interest in the

mechanisms that I am sure the Minister will describe in a moment, and indeed later on Report, to see how this duty will be promoted and evaluated. There are also important mechanisms in this House through the Science and Technology Committee, and I hope that many of the noble Lords who are on that committee will bear that in mind when it comes to looking at how this welcome duty is put into practice.

Baroness Finlay of Llandaff: My Lords, I would also like to formally record an enormous welcome to these changes to the Bill. What has been said in particular by the noble Lords, Lord Willis and Lord Warner, is very pertinent regarding the need to keep questioning. The one thing now that can happen is that those who are actively involved in research can actually question if they get blocked, in a way that they could not before. I think that they will be very bright and questioning people who will make it known if they are not able to do the research that they see needs to be done for the improvement of clinical services.

Indeed, if we can speed up the processes, perhaps we can create an environment in which all patients and relatives understand that a research-rich environment is one that drives up standards of care, and therefore that they are not being experimented on but are being invited to participate when there is equipoise in the highest standards of monitoring that they could possibly have. The governance around research processes in this country is potentially second to none. We may then regain some of those external trials that up until now have, sadly, been bleeding from our shores. The amendments are incredibly important and their universal welcome is very appropriate. The Minister is to be personally congratulated.

Lord Hunt of Kings Heath: My Lords, from the opposition Benches we too welcome the amendments, which very much reflect the debate that we had in Committee on the importance of research. The Chief Medical Officer has paid a visit to Birmingham over the past two days; he gave a lecture at Birmingham University and visited my own trust to discuss research and the role of the NHS in it. My noble friend Lord Warner has put his finger on it: the question to the Minister is how we make sure that the NHS makes a sufficient contribution in future to the development and support of research. The Minister will know that the Chief Medical Officer is a passionate advocate of research and excellence in the NHS, and that is to be warmly welcomed.

There are some issues that need to be tackled. We have already heard about the issue of getting approval for clinical trials. We still have the problem, which has been with us for many years now, of local committees taking far too long and repeating work by other committees. I understand that there are some issues around the fact that, because foundation trusts are separate legal entities, they have to go through the process themselves, but if they join a clinical academic

network some of that work can be reduced. I know that there is to be an announcement at, I think, the end of March about how these clinical networks are to be developed in the future. That is a very important way of enhancing research.

There is no question that the more we do in research, the better the outcomes not only for patients but for the UK's reputation and economic well-being. Healthcare research is surely an area to which we need to give great priority. The noble Earl, Lord Howe, is of course responsible and we are very glad that he is leading this work. However, there is no doubt that, welcome though these amendments are, we should be given some assurance that the Government will now take them forward into the new situation with enthusiasm.

Earl Howe: My Lords, I begin by saying how much I agree with the remarks of the noble Lord, Lord Hunt. There are two very good reasons why research needs to be promoted in the NHS. The first is that it is for the good of patients. The other is that it is potentially for the good of UK plc. If we can attract investment in translational and clinical research to this country, it will be a major advance. The sad truth is that in recent years the UK has been slipping back in the international league table as a location for clinical research. The Government are determined to reverse that trend, as were the previous Government. We are trying our best to build on the foundations that the previous Government set.

Noble Lords have asked me to explain how the Secretary of State's duty to promote research will work in practice. I shall try to do so in a few words. The Secretary of State will use the mandate to set priorities for the health service, based on his legal duties. One of those duties is to promote research within the health service, which is shared by the board and CCGs. What are the tools at the Secretary of State's disposal? The National Institute for Health Research-the NIHR-which is headed by Professor Dame Sally Davies, provides transparent, competitive funding to support clinical and applied health research, the training and development of health researchers, systems to support research and the NHS infrastructure for research. The NIHR will continue to be part of the Department of Health. Its budget of £1 billion is held centrally by the department. The Chief Medical Officer will remain responsible for the NIHR and its budget.

The second main route that the Secretary of State uses, and will continue to use, to support research, is through the NHS. Since the NHS was established, its patient care budget has funded the patient care costs of patients who are taking part in research in the NHS, as set out in existing guidance. In the future, the NHS Commissioning Board

and clinical commissioning groups will ensure that these costs continue to be met through these arrangements. The research costs of these studies are paid by the Government and charity research funders such as the Medical Research Council, the NIHR, Cancer Research UK and the Wellcome Trust. The NHS benefits greatly from the evidence provided by this research.

Let us not forget, too, that the Secretary of State will be held to account for what he does. He must report annually to Parliament on the performance of

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the health service. There is an expectation that he will report on how he has fulfilled his statutory duties.

That brings us to the duties placed on the board. In the document we published, *Developing Clinical Commissioning Groups: TowardsAuthorisation*, we set out the early thinking on the authorisation process. The document highlights that as part of the process CCGs will need to demonstrate how they will exercise important functions, such as the duty to promote research, and the NHS Commissioning Board will seek consistency in the way in which CCGs exercise these duties. Furthermore, a CCG's commissioning plan, and its annual report, as well as the board's annual assessment of the group's performance, will cover the exercise of all the CCG's functions, including the duty to promote research.

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I hope that that has given noble Lords a clear outline of how this is all going to work. We regard these duties as extremely important. These amendments are extremely important, as my noble friend said. I am in no doubt that both the health service and its patients will be better off as a result of them.

Amendment 11 agreed.

Clause 6 : The Secretary of State's duty as to education and training

Amendment 12 not moved.

Consideration on Report adjourned.

House adjourned at 10.11 pm.