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Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

I beg to move,

That the draft Legislative Reform (Clinical Commissioning Groups) order 2014, which was laid before this House on 13 March 2014, in the last Session of Parliament, be approved.

The draft legislative reform order seeks to amend the National Health Service Act 2006 in two ways. First, it will allow clinical commissioning groups to form a joint committee when exercising their commissioning functions jointly. The 2006 Act already allows two or more CCGs to exercise their commissioning functions jointly, but makes no provision for them to do so via a joint committee. Secondly, it will allow CCGs to exercise their commissioning functions jointly with NHS England and to form a joint committee when doing so. The Act already allows NHS England and CCGs jointly to exercise an NHS England function and to do so by way of a joint committee, but it makes no provision for them jointly to exercise a CCG function.

This draft order has already been scrutinised by the Regulatory Reform Committee, and I was pleased with its recommendation that it be approved under the affirmative resolution procedure.

I should say from the outset that the proposed arrangements are voluntary. One party cannot impose the arrangements on another. This allows CCGs to retain their autonomy and to continue to make decisions that are in the best interests of their local populations. They can decide whether to enter a joint committee arrangement with other CCGs. At the moment, the lack of provision for CCGs to form joint committees is placing a burden on CCGs and preventing them from working in the most effective and efficient way. Without the power to form joint committees, CCGs have had to find other means of reaching joint decisions that are binding. That means that they often end up seeking legal advice to ensure that they are on a firm footing, and that adds to cost and complexity without a proper process in place.

As an interim measure, therefore, some CCGs are forming committees in common whereby a number of CCGs may each appoint a representative to such a committee. Those representatives then meet, and any decisions reached are taken back to their respective CCGs for ratification. This leads to additional costs in terms of people's time in sitting on multiple committees, administrative resources, and extra financial cost. Clearly, such arrangements are burdensome, particularly when compared with the simplicity of a joint committee. Primary care trusts, the predecessors of CCGs, were able to form joint committees at which all participating PCTs were bound by the decisions reached, subject to the terms of reference of that committee.

Graham Stringer (Blackley and Broughton, Labour)

The Minister's advice that all the members of a committee acting in common have to report back is at odds with the letter from the Department of Health to a committee dated 8 April 2014, where part of its case is that decisions have to be taken unanimously. That is quite different from having to report back, and it undermines his case about the administrative burden.

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

Currently, because there is no provision for a joint committee, the participating CCGs have to enter into some sort of arrangement that allows them, under their constitutional arrangements, to approve whatever plan of action is discussed and agreed at the committee in common. There could be a process for each CCG to delegate responsibility to the person attending the committee in common to take the decision at the committee on a unanimous basis, as the hon. Gentleman suggests. Alternatively, there could be an arrangement whereby they have to go back to their own CCG and then have a further committee meeting to endorse the proposal that has been discussed at the committee in common. However it is done, it adds complexity and additional cost to the process. It does not stop anything happening; it just makes it more complicated than it has to be.

As I said, such arrangements can be burdensome. Primary care trusts, the predecessors of CCGs, were able to form joint committees at which participating PCTs were bound by the decisions reached. We therefore want to allow CCGs—I stress that we are allowing them, not imposing anything on them, and it is entirely up to them to decide whether they want to participate—a route through which they can take decisions in a properly constituted forum when they are collaborating with other CCGs.

Similarly, the lack of any power for CCGs to exercise their functions jointly with NHS England is causing inflexibility. NHS England and CCGs may wish to act jointly to commission better out-of-hospital services, for example. Making sure that services are integrated around the needs of the patient is the best way of ensuring that care is provided in a safe and compassionate way that most benefits the person involved.

Sometimes there are issues that straddle the commissioning responsibilities of NHS England—the specialised end of the commissioning spectrum—and the responsibilities of the local CCG, and it seems to me that it is worth trying to secure joint working on both sides of that divide in the most effective way possible. The amendment would allow CCGs and NHS England, as co-commissioners, to develop and agree strategic plans and delivery processes that take into account the effects of services across the whole pathway—from specialist to local commissioning—supporting design and continuity of services across primary, secondary and

community care.

For example, CCGs and NHS England may wish to review service delivery across specialised services commissioned by NHS England and any impact a redesign may have on non-specialised acute services commissioned by CCGs, in order for services to be designed and delivered to achieve the best possible outcome for the population served. The inability of NHS England and CCGs to jointly exercise a CCG function, and to form a joint committee when doing so, makes it more difficult to make timely decisions, which can delay the ability to improve patient safety. The proposed amendments will encourage the formation of new commissioning partnerships, allowing the most effective approach to be used.

When CCGs agree to form a joint committee, they will have the freedom to agree terms of reference, including voting arrangements. They could, therefore, agree between them to allow decisions to be reached by a majority.

Equally, however, if a CCG wants to be absolutely sure that there would be no adverse effect on the area it serves, it could, as part of the agreement to enter the joint committee, require unanimity before anything is approved. This will not dilute the emphasis on local decision making.

It is important that patients, members of the public and other stakeholders are able to see how joint committees operate and, in particular, how decisions are made. CCGs must specify in their constitutions the arrangements made for the discharge of their functions and for ensuring that there is transparency about the group's decisions and the manner in which they are made. That applies whether CCGs are discharging their functions individually or as part of a joint committee with other CCGs.

CCGs already have a duty to involve patients and the public in plans and decisions about commissioning arrangements. This involvement can be by way of consultation, by the provision of information or in other ways. We would still expect CCGs to make suitable arrangements to make sure that that duty is complied with when exercising their functions in a joint committee. In other words, the duty is exactly the same: arrangements for public involvement apply equally to decisions made by CCGs in a joint committee as they do to those made by CCGs individually. There is no reason why decisions taken in joint committees should be any less transparent than any decisions taken individually. The creation of joint committees would enable CCGs to take binding decisions without the need for separate ratification of complicated delegation structures.

CCGs are still accountable as individual organisations—they do not lose that by entering a joint committee. Joint arrangements mean that each CCG is still liable for the exercise of its commissioning functions, even where they are being exercised jointly with another CCG or with NHS England. To be clear: joint working does not abrogate a CCG of their responsibilities as a statutory, independent and accountable organisation. The proposed arrangements will not lead to reconfiguration by the

back door; they will not affect the existing processes, the tests that any significant service redesign needs to follow or the role of the overview and scrutiny committee locally.

The proposed amendments build on existing powers by giving CCGs greater flexibility and control in the way they work. They return, in a sense, to the arrangements that were in place with primary care trusts. The changes will support more effective and efficient joint working and allow discussions about service redesign to take place across the local health economy. As CCGs become more established organisations, they need to have more flexibility to work together and with NHS England. In any commissioning structure, there will always be some decisions that need to be taken locally and some that span a wider population.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

The draft order makes important changes, so I welcome the fact that we can debate it properly on the Floor of the House. Hon. Members will forgive me if I say that the reason we are here today is to try to clear up yet another problem

created by the Government's NHS reorganisation and by the Health and Social Care Act 2012, which will go down in the annals of parliamentary history as one of the worst pieces of legislation this House has ever seen.

Richard Fuller (Bedford, Conservative)

Will the hon. Lady give way?

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

No. I will make some progress. The hon. Gentleman may want to listen to what the Secretary of State for Health admitted in a letter to the chair of Healthwatch England on 11 August:

"The Health and Social Care Act, when it established CCGs, did not make provision for CCGs to form joint committees and other CCGs. PCTs previously had this provision in legislation and many formed joint committees to progress partnership work.

Health organisations, including CCGs, have expressed concerns about CCGs' inability to form joint committees that are able to make binding decisions. This inability has brought many practical challenges in working together on issues that cut across boundaries, such as continuing healthcare, patient specific funding requests and service change"

across the country. I do not know whether the Minister wants to explain why the Health and Social Care Act removed that provision, as the Health Secretary admitted in the letter to Healthwatch England. Does he want to stand up? If not, I will make some progress.

The Minister was fortunate not to be on the Committee that looked at the Health and Social Care Bill twice, so he will not know that Opposition Members repeatedly warned during its passage that CCGs would often be too small to secure effective changes to services across wider areas. We have consistently made it clear that the only way we can get the big changes we need to be able to improve care for patients, including by specialising some services in regional centres and shifting others out of hospitals into the community and towards prevention, is by working in partnership across larger areas.

In principle, we support the need for collaboration and for CCGs to come together both with one another and with NHS England, particularly in wanting to commission good services across primary, secondary, community and specialist care. However, serious concerns have been raised about the draft order by local healthwatch organisations, Healthwatch England and some of the organisations that responded to the consultation, and my hon. Friends may want to raise real concerns. I will go through the concerns in some detail.

The Minister has talked about the fact that CCGs will remain autonomous, but many of them are concerned that that is not written into the draft order. Many CCGs feel that they are coming under increasing pressure from NHS England and some of its local offices. They are concerned that the draft order might take away their autonomy, forcing them into committees and decisions that they do not think are in the best interests of local people.

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

Will the hon. Lady give way?

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

If the Minister will give me two seconds, before I allow him to intervene I want to

read out what NHS Clinical Commissioners—the independent collective voice of CCGs—said in its response to the consultation. It said that it

"would not want the Legislative Reform Order to become a 'back door mechanism' for reconfigurations."

It asked for

"some assurance the change will continue to respect the decisions of CCGs as statutory bodies",

and it insisted that

"CCGs must not be pushed into shared arrangements with NHS England if it is not in the interests or needs of their population".

I have heard the Minister's words about that, but the draft order has not been changed. Perhaps he would like to say more about it.

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

It is worth putting it on the record again that this does nothing to change the legal duties of a CCG and nothing to put any pressure on a CCG to enter any arrangement, either with other CCGs or with NHS England. If a CCG feels under pressure, it has every right to resist it, if it feels that to do so is in its interests or those of its local community. This is entirely voluntary. With regard to the legal duties, nothing changes.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

If one of the 22 CCGs in the east midlands, part of which I represent, decided that it did not want to come together to commission one body to perform NHS continuing health care, for example, because it did not like it, could it say no?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

Absolutely. There is nothing in the proposed amendment that could force any CCG to do anything. I suspect that in such circumstances common sense might prevail, as everyone recognises that on something such as NHS continuing health care, collaboration makes a lot of sense, as the shadow Minister indicated, but there is

nothing to force anyone to do that.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

Will the Minister also clarify that if NHS England wanted to form a joint committee with CCGs in the area, it could not force them into it?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

This is a good exchange of views. Again, I can confirm that this is about a voluntary arrangement between a CCG or CCGs and NHS England. There is no compulsion at all.

...
Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

I am very grateful to the Minister, who has perhaps been much clearer on that point than the Minister in the other place was.

The Minister has been clear that CCGs will not be forced into joint committees, but the second concern relates to majority voting in the committees. He will know that the Regulatory Reform Committee's report cites a couple of CCGs that have been concerned that:

"Joint committees would be able to take majority decisions on behalf of their constituent CCGs and NHS England, and so individual CCGs might find themselves accountable for implementing policies that their members did not consider to be in the best interests of the local population."

To put it bluntly, if one or two CCGs on the committee disagree, they can be outvoted. Is that the case, and would it be possible for NHS England to have the casting vote on a committee?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

It is helpful to respond straight away on these specific points. Again, I stress, as I think I made clear at the beginning, that it is up to the participating CCGs to determine what voting arrangements should

be in place. If they felt that unanimity was required in order to protect the interests of the community they serve, they could make that a condition of entering the joint committee. It is entirely up to the participating CCGs to agree the rules.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)
I am grateful to the Minister for that helpful clarification.

The third concern has been raised by the Association of Directors of Adult Social Services and by the Local Government Association. They are concerned that any joint arrangements between CCGs, or between CCGs and NHS England, must be fully aligned with the geographical boundaries and strategies of local health and wellbeing boards. That is not only because we have to get health and social care working together, with council care services and the NHS, but because of accountability issues. Perhaps the Minister will say something about that later.

The last two concerns about the draft order are, for me, the greatest. The fourth is about how the joint committees will be held to account for the decisions they take and how patients, the public, local healthwatch, health and wellbeing boards and Members of this House can know what decisions are taken and hold the joint committees to account, because I understand that they will not be required to meet in public. I raise that concern because it has been raised in two letters from the chair of Healthwatch England to the Secretary of State. In her first letter on 16 July, she wrote:

"I am concerned about the impact this reform could have on the statutory role of local Healthwatch, the integrity of local accountability mechanisms, and meaningful public involvement in decisions about service redesign."

She goes on:

"Whilst I recognise the important role CCG collaborations can play in the effective commissioning of health and social care and the transformation of traditional service models, I am sure you will agree that it is vital they are accompanied by strong accountability and engagement mechanisms. This is of particular importance given the scale of decisions being made by joint committees, and our anticipation that many more of these joint arrangements will be put in place. Without these safeguards in place, the public are far less likely to understand, or be accepting of, the changes that happen in their community."

She recommends that the draft order be strengthened, and makes four proposals:

"Ensure CCGs acting in collaborative arrangements have in place adequate mechanisms meaningfully to engage the…community."

She suggests a

“mandatory non-voting constitutional seat on Committees…for local Healthwatch.”

and a

“duty on all lead or co-ordinating commissioners to have due regard to existing local agreed priorities…(including Joint Strategic Needs Assessments and Health and Wellbeing Plans).”

Finally, there should be

“a duty on all lead or co-ordinating commissioners to act within existing local accountability mechanisms”

including local health and wellbeing boards.

When the Secretary of State replied to Anna Bradley, he said he felt that mechanisms for public accountability were in place and that there would be no proposed strengthening of the order. In her reply to him on 20 August, Anna Bradley stated:

“I do not yet share your confidence that the new joint committee arrangements will address our concerns about transparency and accountability.”

The Government said throughout the Health and Social Care Act 2012 and all their reforms that there should be “No decision about me without me”, but the patient and public voice, local and national Healthwatch, has said it does not believe that that strong patient and public voice will be effective under the proposed order. The Minister needs to respond to that.

Finally—this is a particular concern of mine—one decision that joint committees can take concerns individual patient-specific funding requests for things such as NHS continuing health care. Any hon. Member whose constituent has applied for that kind of funding, or funding for a number of different areas, knows that it can be difficult to get to the bottom of those decisions. I had a particular problem with Greater East Midlands commissioning support unit, which manages continuing health care for the 22 CCGs in the east midlands. I have barely been able to get any information out of it about the bad decisions it has taken, and that is a real worry because I am concerned that the joint committees will repeat that. How will we know how those decisions are taken or hold them to account?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

Perhaps the hon. Lady will give me details of that concern in her local area. It is important that we hold the different parts of the system to account, and she should

be able to establish the position. I am happy to pursue that matter for her if she would like.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

I am grateful to the Minister. I will forward him my concerns, just as I have done to my local CCGs and the chief executive of NHS England.

To conclude, Healthwatch raised these concerns in relation to a particular issue in Greater Manchester and the Healthier Together project, where 12 CCGS have grouped together to reconfigure services. The local healthwatch is concerned that under the draft order some of the problems it has seen with Healthier Together could be replicated. For example, I understand that governance meetings for Healthier Together started to take place in public only in March 2014. That was after major decisions—such as the model for service reconfiguration—were discussed in a closed session of that committee. The local healthwatch remains concerned about the lack of clarity on planned public involvement in Healthier Together in future, and, like the local healthwatch, Healthwatch England is concerned that the joint committees will not be accountable to patients and the public.

Hon. Members across the House will say that previous primary care trusts were sometimes not open and accountable, and I may have shared some of those concerns. This is a chance to put things right, but I am concerned that the draft order is not strong enough and I know other hon. Members will also raise that point.

Jeremy Lefroy (Stafford, Conservative)

I rise to support the order in general, while wishing to raise some serious concerns in Stafford and further afield in Staffordshire. I will not rehearse the circumstances there, other than

to say that two of our hospitals, Stafford and Cannock Chase, are currently being integrated, the first with the University Hospital of North Staffordshire and the second with Royal Wolverhampton hospital, while at the same time an inquiry is being held into the entire health economy in Staffordshire. It is characterised as a fragile health economy—which it absolutely is—and we await the report, due in the next few days, with keen interest.

Four CCGs in Staffordshire—Stafford and Surrounds, Cannock Chase, Stoke-on-Trent and North Staffordshire —have come together to commission cancer and end-of-life services. Like all Members, I have no problem with the idea of improving outcomes for cancer patients. Together with Macmillan, the CCGs have consulted heavily with

local cancer patients, and that extremely valuable work has raised many concerns about the co-ordination of services in Staffordshire that I share—constituents have come to me with the same concerns. That is all well and good and I agree with that work.

We have very strong concerns, however, over the proposal for improving those services. As I understand it, everywhere else Macmillan has worked with CCGs and NHS England, a co-operative and collaborative approach has been adopted to improve the co-ordination of cancer and end-of-life services. CCGs have to commission services from many different providers—37 in Staffordshire, I believe—so it is a complex operation and I understand why they want to simplify it, but in Staffordshire, instead of saying to existing providers, "How can we work better together? Could someone take the lead and work with us to provide better cancer and end-of-life services?" the services have been put out to tender for 10 years. These services are worth £120 million a year, which is £1.2 billion over 10 years.

I have two major concerns and plan to make a direct request to the Minister at the end of my remarks. First, an extremely large reorganisation and tender process are being imposed on a fragile health economy that is going through an extremely difficult amalgamation of two hospitals into other trusts which we must support and must be done properly to ensure patient safety and quality of care. However, one of the acute trusts, UHNS, which will be taking over Stafford hospital and will effectively—there is no other alternative—be the one providing acute cancer services in the area, has also expressed grave concern.

As a result of that concern, I and other colleagues from Stoke-on-Trent and elsewhere wrote to the CCGs asking them at least to suspend the process until the extreme fragility of the health economy had been made more robust as a result of the dissolution of Mid Staffordshire NHS Foundation Trust. To date, that has not happened. There have been public meetings. I addressed one, with others, on Saturday in Stafford. I do not want to do down the work done with many patients in my constituency and others who want to see improvements in cancer and end-of-life services. I do not want that work to be lost at all, but I believe there are other ways to ensure that the co-operation and co-ordination are better.

My second point is about consultation. The shadow Minister raised important points. Does consultation have to happen independently in each of the CCGs involved in the grouping, or will it be done en masse, in which case, will there be assurances that the consultation

will be balanced across all the CCGs involved? In this case, as I say, we have had quite extensive consultation with patients, but at the meeting I addressed in Victoria park in Stafford on Saturday, one cancer patient raised his concern that he had not been consulted. Members of Parliament from the area have not been consulted; nor indeed have the main providers of acute cancer care in the area—the University Hospital of North Staffordshire and, for the time being, the Mid Staffordshire NHS Foundation Trust. They provide very good cancer treatment and care, although the

co-ordination and other services such as psychological counselling, financial advice and so forth could be considerably better in some cases.

There are serious questions about the consultation with all relevant bodies. The Health and Social Care Act 2012 states that the clinical commissioning group

"must make arrangements to secure that individuals to whom services are being or may be provided are involved"

in various ways, including

"in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."

I believe that that has not happened in this case. It must happen, which is why I am asking for at least a suspension of the process until it has happened.

Page 6 of the fifth report of the Regulatory Reform Committee on the draft regulatory reform order refers to

"concerns about possible loss of protection"

because

"Joint committees would be able to take majority decisions on behalf of their constituent CCGs and NHS England, and so individual CCGs"

might find themselves increasingly concerned during the process, as I know a couple of them are at the moment. They could find themselves still heavily involved, having committed substantial financial resources, but as a result of the consultation and listening to their patients and their members they no longer want to go ahead with the process. They would probably be outvoted.

I conclude by asking the Minister to look very closely at this issue, which was featured in *Private Eye* this week. I ask that some common sense be brought to bear on the situation, if possible, and I ask for a slowing down or suspension of the process until we have a better health economy in Staffordshire and until we are clearer about the consultation process that needs to happen.

Graham Stringer (Blackley and Broughton, Labour)

I rise to oppose the order for two primary reasons. I shall attempt to divide the House at the end of the debate.

My first reason relates to the Legislative and Regulatory Reform Act 2006. Right hon. and hon. Members may not be over-familiar with the Act, but its purpose was to allow regulatory burdens to be taken away if it was unlikely that Parliament would find time to debate the issues and if they were not controversial. It provides in the Act—this is why we are debating the order today—that if the Regulatory Reform Committee is not unanimous, there should be a debate on the Floor of the House. If there is a majority against the order, a longer debate in a different form would take place. The Committee did not unanimously support the order—I am not aware why

one Member voted against it—and that has provided an opportunity to look at the process governed by the 2006 Act and assess whether the order complies with it.

In the simplest, most common-sense terms, an order would be passed if it would remove a burden and was non-controversial. I think that this order is controversial, and I do not think that it meets the conditions in the Act. Those conditions exist because, effectively, the process and the order concerned will relieve the House of the burden and responsibility of going through three Readings in this House and three Readings in the other place, so we have to be certain that this order is non-controversial.

First, there is the question of the consultation on the order. The report states that the Department consulted the better regulation unit, and was told that, as the order would remove only an administrative burden,

"it would be appropriate to conduct a targeted consultation rather than a full public consultation."

I do not think that that is appropriate. Almost everything to do with the structure of the health service at the present time is controversial. My constituents and, certainly, Members of Parliament have views and concerns about that, but they were not directly involved or consulted about the process, and I think that that is a mistake in itself.

Then there is the claim that the order will remove an administrative burden. When I questioned the Minister earlier about the administrative burden, I tried to explain that, at present, clinical commissioning groups can organise themselves into committees, and can make decisions if those decisions are unanimous. They do not have to report back to anyone, so there is not an administrative burden there. There are other ways in which they can co-operate: they can reach legal agreements, or, indeed, they can report back, as in the example given by the Minister.

I do not believe that there is an administrative burden to be removed. However, I do think that there is the potential for repression of a clinical commissioning group. While it is voluntary to enter into these arrangements, if clinical commissioning groups entered into them in good faith and then encountered a more controversial issue, it would be difficult for them to move out; and if they could move out, that would return them to exactly the position in which they would have been had they

been entering into a voluntary agreement with a committee in common, which means that there is no removal of an administrative burden. If that is the case, we do not need the order. If it not the case, it is possible for a majority of clinical commissioning groups to overrule the interests of other CCGs.

In my view, the Regulatory Reform Committee and the Department have not followed the rules set down in the Legislative and Regulatory Reform Act 2006, and the House should reject the order on that basis alone.

I am not engaging in a theoretical discussion, and I am not going to ask the Minister to listen to a debate that would be exactly the same as our recent Westminster Hall debate about the proposals in "Healthier Together". However, a consultation—a very flawed consultation—is currently taking place in Greater Manchester. The health trust that covers Wigan, Wrightington, and Leigh in the west of Greater Manchester, and the one that covers south Manchester and Wythenshawe, fear that the proposals

are unreasonable, and feel unable to support them at present. If the proposals were to go ahead, it would be possible for a majority of the 12 clinical commissioning groups that operate in Greater Manchester to make a decision that would impose changes on the hospitals in those clinical commissioning areas which are not wanted by the clinical commissioning groups.

As I said, the consultation is deeply flawed. It involves upgrading some hospitals to specialist hospital status and in effect downgrading other hospitals. Incidentally, three of the hospitals—those in north Manchester, Bury and Tameside—have not been consulted on the proposed changes in those hospitals.

The local healthwatch team said that the way in which our CCGs are operating is outside the law and that this proposal would put them inside the law. We can see the reason why: they want a majority decision, not a decision that would represent the areas of Wigan and south Manchester. I could talk a great deal about the rest of the "Healthier Together" proposals, but we debated those details in Westminster Hall. I do not think that the proposals are in the interests of the people of Greater Manchester. They try to jump the gun before the general election. It would be better for the decisions to be made by whichever Government are in power after the general election.

The consultation documents omit to mention the financial situation in which Greater Manchester finds itself—a £1 billion deficit is projected in the next two and a half to three years—and make proposals that could lead to the closure of hospitals, while pretending that they are only small decisions. The consultation paper wanders all over the place—through primary, secondary and tertiary care—but at the core of the consultation is the change in status of a number of hospitals in Greater Manchester. I worry that, if the CCGs work together and make majority decisions, the proposals in the "Healthier Together" consultation will be used as a blank cheque—health authorities in Greater Manchester will have carte blanche to do what they wish,

without taking account of the views of the people of Greater Manchester.

Andrew Lansley (South Cambridgeshire, Conservative)

I did not intend to say much about the regulatory reform order but I am prompted to do so to ask some questions and to respond to one or two points. I will not rise to the bait of the shadow Minister, Liz Kendall, other than to say that I thought it deeply ironic that, in railing against the Health and Social Care Act 2012, she instanced for most of her speech the views of Healthwatch England, a body representing patients that was created under that Act. It remedies one of the greatest failings of the last Labour Government, who demolished successive efforts to give patients a genuine voice.

I was grateful to my hon. Friend Jeremy Lefroy for instancing the Act's requirements on CCGs in relation to patient involvement. "No decision about me without me" is at the heart of the principles of reform. They are set out in the primary legislation. This reform order does not in any way reduce the statutory requirements on CCGs, which

must ensure that any joint arrangements they enter into match up to the requirements under the Act.

Under the Act, the essence of CCGs, compared with primary care trusts, is that they are independent statutory bodies. I will not follow Graham Stringer and discuss the process of the regulatory reform order, but he is right: it is not theoretical; it is practical. There is a practical reason why we are in a better place, with CCGs enjoying statutory authority compared with PCTs. Although they were statutory bodies, they did not have the authority that exists presently under statute to deliver and commission services in the interests of the population they serve, without interference or instruction by others. Therefore, as the Minister rightly says, if they wish to enter into these commissioning arrangements, they do so on a voluntary basis. My view is that in the relatively short intervening period under the Act, they have probably underestimated their capacity as statutory bodies to enter into arrangements voluntarily, exercising their statutory authorities as long as they do not improperly delegate their responsibility.

That takes us back to the practical issue. I remember that in 2006, also in Manchester, as it happens—some Members will recall this very well—there was the reorganisation of maternity and children's services across the city. I suspect that what is being complained of in relation to Healthier Together is exactly the same kind of complaint as was made against that consultation, which had its deficiencies, of which I complained.

Leaving aside whether the consultation was good, bad or indifferent, the point is it did arrive at a position. I can remember talking to the chief executive of the primary

care trust in Salford and also, separately to the chief executive of Salford Royal, and they were told that, as a consequence of the configuration, although the primary care trust wished to commission maternity services and paediatric intensive care services from Salford Royal and the hospital wished to provide them, they were not allowed to do so because the Joint Committee of Primary Care Trusts was preventing them from doing so. In fact, as they were, in effect, in a hierarchy under the strategic health authority, under past legislation they could have been required—forced—to go down that route, and were forced to do so.

That, in my view, is not the position now, and it still will not be the position under these proposals because they are voluntary. If a CCG takes the view that it is in the best interests of its population to deliver some service, it must take a decision consistent with that view. If that means it enters into a voluntary arrangement to deliver that, that is to be supported. If it takes the view that it has to depart from any such arrangement in order to secure the best interests of its population, it must go down that path as well. It would be wrong, under this order or otherwise, for it not to do what is in the best interests of the population it serves.

Finally I have a question, which in this respect is an important one following on from what the shadow Minister asked. In commissioning—quite often when commissioning, for example, out-of-hospital and community services—it is right that one may well need to co-ordinate across CCG services and NHS England's responsibility for the commissioning of primary care services or, indeed, other services such as dental care and pharmacy services. That being the case, however, it is also important to

commission across social care services and some public health aspects of local authorities' responsibilities. With local authorities having their own statutory authority, and CCGs likewise, it is perfectly possible for them to enter into joint commissioning arrangements, and they do so. I hope the Minister will be able to reassure me that not only are local authorities and the geography of health and wellbeing boards and scrutiny to be respected in terms of the way in which CCGs enter into these kinds of voluntary arrangements, but also that where they enter into joint commissioning arrangements they are able to do so in ways that can mesh together NHS England, CCGs, as necessary, and local authorities.

I urge that at the heart of this is a recognition that CCGs now have statutory authority. That is what is different. They are accountable to their local community, and must set out a commissioning plan and agree it with their health and wellbeing boards. If they try to enter into an arrangement which is contrary to the best interests of their population, as set out in that commissioning plan or by agreement with the health and wellbeing boards, clearly it would be deficient and it should not be able to be pursued.

, Conservative)

It is truly a pleasure to listen to my right hon. Friend Mr Lansley and to follow him in the debate. I am a member of the Regulatory Reform Select Committee and it was my vote that enabled the House as a whole to debate this measure, which might, on paper, seem rather arcane. Graham Stringer asked why we are debating it in this way. We are doing so because the core dilemma in much health reform involves the tension between local decision making and common advance. For many people, there is a tension between the priority to localise decision making and the need, as seen by professionals such as the doctors and clinicians whom we trust, for some decisions to be made on a common basis in order to achieve overall advances in health care. It can be difficult to find the appropriate boundaries as we try to resolve that tension.

I felt that it was important to bring this matter to the House so that other hon. Members could have a chance to talk about the experience in their own localities. The issues in Greater Manchester have already been mentioned, and my hon. Friend Jeremy Lefroy has mentioned the issues in his own area. I also felt that it was important to herald one of the most important attributes of the reforms that my right hon. Friend the Member for South Cambridgeshire introduced, which was to enable, as far as possible, decision making on these issues to take place locally and to ensure that those local decisions were led not by politicians or bureaucrats but by doctors. A concern has been expressed that this change would somehow draw us away from those reforms.

The shadow Minister, Liz Kendall, asked some extremely pertinent questions, although she perhaps got off to a bad start by taking the political apparatchik line and suggesting that certain problems were the result of the reforms. This is actually about one of the best parts of those reforms, which allows local people to make decisions.

That was reflected in the widely quoted comments made by Anna Bradley, the chair of Healthwatch England. In her note, she said that

“we are concerned that the proposed reforms could create the conditions for CCG decision-making to become disconnected from the transparency and accountability mechanisms put in place by the Government’s health reforms”.

She recognises, as do many hon. Members, the importance of the tension. She also referred to it in a press release, in which she stated:

“We understand the benefits of commissioners working collaboratively but it remains crucial that local people are involved, asked what they want and understand how decisions will affect the way services are delivered in their area.”

In my own area in Bedfordshire, we have been having a collaborative exercise between two clinical commissioning groups, and they have done an extraordinarily good job of communicating and maintaining local decision making.

Graham Stringer (Blackley and Broughton, Labour)

The House owes the hon. Gentleman a debt of gratitude for bringing the order before us today. Will he tell us whether, in the example he is giving, the order would help, hinder or be neutral?

Richard Fuller (Bedford, Conservative)

I am not an expert, but in that particular instance I do not think I would fear the joint committee making a different recommendation from the current committee in common, although it has yet to come back with its report. The point is that the hon. Gentleman and others have aired important questions for the Minister to answer. He has answered some of them, and that has been the purpose of the debate today.

Underpinning all this is the fact—whose importance I hope the Minister will emphasise in his response—that people want important health decisions to be taken locally. They can be persuaded of, and they can understand, the issue of common advance, but they want to know that a decision is being taken locally. I think that the Minister dealt with this in his response to the shadow Minister, but I would be grateful if he answered these points quite specifically. First, am I right in thinking that he said that decisions on the part of commissioning groups to go into joint committees were voluntary, rather than compulsory, and that it would therefore remain possible for them to continue to set up committees in common if they so wished? My second question—

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

rose—

Richard Fuller (Bedford, Conservative)

I am happy to give way to the Minister iteratively, or he can wait until I have given him the full menu. Which would he prefer?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

The answer to that question is yes, absolutely; I repeat that this is a voluntary act by any CCG. To address one of the concerns raised by the shadow Minister, let me say that there may well be circumstances in which CCGs want the rules of the game established at the start of the joint committee saying that there will be circumstances in which they can withdraw from that committee. So there are no circumstances in which any CCG needs to feel that it will be oppressed in any way by its neighbouring CCGs, NHS England or anyone else.

Richard Fuller (Bedford, Conservative)

I am grateful for that clarification. My second question is on the issue of voting on the

joint committees. To be effective, is it a requirement that joint committees should be based on unanimous voting only and that all CCGs would have to agree, or will joint committees be substantially based on majority voting? Is it open to CCGs to create joint committees with majority or unanimity voting depending on how they wish to set those up?

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

rose—

Dawn Primarolo (Second Deputy Chairman of Ways and Means; Bristol South, Labour)

Order. May I say to the Minister that I know he is trying to be helpful, but he will soon be seeking to answer this debate? We have only one more speaker to go, so to help the flow of the debate perhaps Members could finish their speeches and then he can respond.

Richard Fuller (Bedford, Conservative)

I am grateful for the direction, Madam Deputy Speaker. My third question relates to the legalities and costs, which were mentioned by the Minister and were in the justification for making this change from committees in common to joint committees. I am still a little at a loss as to what those legalities and costs are. What costs are currently incurred or are anticipated to be incurred, and why would the costs be substantially less with joint committees? I am not looking for a generic answer such as, “There are some legal costs here and legal costs there.” I am looking for something specific, because if we are to make a change, we have to demonstrate

that a substantial administrative burden has been taken away.

My fourth question relates to the impact of the change on existing committees in common. I think it would be correct to say that the Healthier Together review in Manchester is proceeding as a committee in common, not as a joint committee. Would that be the case if this change is made, or would it be possible, either automatically or by choice, for existing committees in common to be transferred to joint committees with the same decision rights that joint committees would have? I am not too clear as to the position for committees that are already extant.

My fifth question relates to the Minister's statement that committees in common somehow place a "burden". I would be grateful for his clarification that he does not believe that the essence of localism, which was a substantial intention behind the reform introduced my right hon. Friend the Member for South Cambridgeshire, is the burden to which reference is being made. Sometimes one fears that there is tension between localism and common advance. If we allow the people who are on joint committees and their decision making to get further and further away from the people, the burden of having to go back to get local approval is lost. I hope that the Minister can clarify that that is not what is meant in the order's reference material.

Finally, there has been a lot of commentary about the fact that it is up to committees to change their minds later on and to decide whether it is a joint committee or not. But the Minister can be clear that not all the consequences of what a committee will find can be known at the outset. Can he clarify whether it is possible for CCGs that are already signed up to joint decision making on joint committees by majority voting to

change their rules, or are they bound by those rules once they have signed up to them? I am very grateful for the opportunity to debate these issues on the Floor of the House, and I look forward to hearing the Minister's response.

Sarah Wollaston (Totnes, Conservative)

I apologise for missing the opening speeches, but I was chairing the Health Committee. I am delighted to have been here to hear my hon. Friend Richard Fuller. I absolutely agree with him, and am grateful to him for raising this issue of the tension that exists between localism and the decisions that are being made in good faith by clinical commissioners. There is a need for us to engage local people in decision-making to ensure that we get the best possible outcome for them.

I am sure that other Members have raised concerns about Healthwatch and the possibility of the local voice being squeezed out. Will the Minister address the issue of the time scale that is often given to local people to consider quite detailed proposals? Indeed, detailed proposals will be given to local health and wellbeing boards at Devon county council with only a day's notice, and there is no obligation to include local healthwatch. We need guidance in that area, especially if we are to

have committees in common, which I support. I will support the regulatory reform order, as it is a good thing. Like my right hon. Friend Mr Lansley, I think that we could go further and involve other groups in these permissive arrangements. As he will know, for people living on the boundaries of clinical commissioning groups, such arrangements do not always appear to be logical. This will allow commissioning to take place over a wider area with better outcomes for patients and often with great saving. I absolutely support the measure, but the concerns expressed by Healthwatch, which have also been expressed to me, need to be addressed.

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

I am grateful to all Members for their contributions to this debate. Regarding the shadow Minister's contribution, I am pleased to hear that she is supportive, at least in principle, of this capacity to facilitate greater collaboration at a local level. As my right hon. Friend Mr Lansley said, it is rather ironic that this is all about a reformed health system that has much better clinical and democratic legitimacy than the one we inherited from the Opposition. I notice that no one is out there waving banners demanding the return of the primary care trust. Ultimately, that body had no accountability to the local community—*[Interruption.]* No, it had no accountability. Its accountability was entirely upwards to the strategic health authority and to the national level.

Liz Kendall (Shadow Minister (Health) (Care and Older People); Leicester West, Labour)

That is completely over the top. Sometimes I have had great trouble getting any answers out of my CCG. Sometimes they have been good and sometimes they have been bad. I have also had great trouble getting anything out of the commissioning support unit. *The Minister should not paint some super rosy picture of fantastic accountability and patient involvement, as there are still some real issues.*

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

I fully understand that we should always be arguing the case for greater openness and for greater legitimacy and accountability. All I am saying is that the system that we inherited had no local legitimacy at all, and that this is a significant improvement.

The shadow Minister talked about alignment with health and wellbeing boards. I think that that will almost always be the case. In my county of Norfolk, there are several CCGs, but all are operating within a health and wellbeing area and a local health economy. There may be circumstances in which more than one health and wellbeing board area is being considered, and I think that that is the case within the

Manchester area and the discussions that are going on there. But in most circumstances, the sort of collaboration that we are talking about will be consistent with the health and wellbeing board area.

The shadow Minister also asked how CCGs will be held to account for joint decisions. When they act in joint committee, they will be subject to the same duties as when they act on their own and the accountability they face will be exactly the same. It is very important to reiterate that point.

The hon. Lady also raised concerns about the issues that Healthwatch England has raised, and I stress that the Department, NHS England and Healthwatch England are working together to ensure that CCGs have the materials and resources they need to support their effective and accountable collaboration and local healthwatch organisations and others are supported to hold the system effectively to account. Everything on our side is about facilitating accountability at a local level, not undermining it.

My hon. Friend Jeremy Lefroy raised concerns about the issues in his area. I think that it is fair to say that they are not directly related to the proposals under the order, in that his concerns are about issues under the current arrangements rather than any potential impact of the proposed change. I want to reassure him that nothing in the order in any way undermines effective accountability for changes. I think it would be dangerous for me to go down the route of responding to the points he raises about his local circumstances, and I suspect that you, Mr Deputy Speaker, would rule me out of order if I tried to do so.

Jeremy Lefroy (Stafford, Conservative)

The point I wish to make is that in our case the group of CCGs that is seeking to put out to tender the commissioning of end-of-life and cancer services appears to be abrogating its responsibilities for commissioning. These are clinical commissioning groups, yet they seek to put out to tender the commissioning of vital services for our constituents for 10 years. One might be concerned that the groupings would seek to do more like that.

Norman Lamb (The Minister of State, Department of Health; North Norfolk, Liberal Democrat)

My hon. Friend expresses a concern about what is happening at present and he is absolutely right as a local Member to challenge, question and hold to account the clinical commissioning groups in his area, but I do not think that there is anything in the order that changes the arrangements about which he is concerned. Indeed, I think that streamlining the system so that there is more effective accountability and less opaque decision making is better for local people.

Concerns were raised that joint committees might not meet in public. Joint working does not need to mean that it will take place behind closed doors and exactly the same responsibilities will apply to CCGs when they work jointly as when they work on their own or through committees in common. Indeed, I understand that committees in common have already on occasion met in public and I would always encourage accountable organisations to operate in public wherever possible. That is the approach that I seek to advocate.

In response to concerns raised by my hon. Friend the Member for Stafford, let me make the point that the requirements for service change that apply to a CCG regarding any major proposal for change will still apply, including that for appropriate consultation. Joint committees might want to consult jointly to co-ordinate their communications to patients and the public where appropriate, but the duty remains on the clinical commissioning group and it must demonstrate that it is meeting it.

Graham Stringer again raised concerns about the process going on in Manchester and he and I debated the matter in debate to which he referred. I stress that his concerns are about actions taken under the existing regime, with a committee in common, rather than under the proposals in the order.

The hon. Gentleman expressed worry about the appropriateness of the order under the Legislative and Regulatory Reform Act 2006, but both the Regulatory Reform Committee and the Delegated Powers and Regulatory Reform Committee judged that a satisfactory case had been made for the LRO and that the order met the tests under the 2006 Act, so his concerns are misplaced. Although he has legitimate and genuine concerns about the process in Manchester and whether it is right for local people, I suggest to him that accountability will be encouraged and improved if the new system is less opaque and more clearly set out in legislation than the existing one. All the things about which he worries are happening under the existing arrangements.

It is up to CCGs to set out terms of reference for any joint committee arrangement, such as the scope for decision taking, and arrangements for membership or voting. They may also determine situations in which a CCG would wish to withdraw from a joint committee arrangement. The hon. Gentleman was worried that one CCG might feel oppressed or bullied by others, but it could set the terms of reference so that it could withdraw in defined circumstances, so his concern is misplaced.

My right hon. Friend the Member for South Cambridgeshire spoke about important improvements in democratic accountability and clinical leadership in commissioning, and the benefits that that secures. He asked about collaboration on commissioning not only between CCGs, or between CCGs and NHS England, but, critically, with local authorities and public health bodies. Such collaboration is facilitated, and he and I share the view that we should try to promote a more permissive NHS health and care system within which local arrangements may be put in place to ensure that the resources available throughout the health and care system are used as efficiently as

possible. We should encourage such joint commissioning, rather than putting blocks in its way.

My hon. Friend Richard Fuller rightly talked about the tension that exists between local decision making and clinical best practice. This approach is all about managing that tension, rather than trying to pretend that it does not exist. He made the vital point, with which I agree, that people want health decisions to be taken locally, and we should try to facilitate open discussion and debate about the difficult choices that we sometimes have to make, rather than taking power away from people, which just undermines confidence in the system.

My hon. Friend asked about unanimity, so I repeat that if a CCG wants to enter into a joint committee arrangement, but to protect its position on behalf of its local community, it can insist that unanimity is the basis on which decisions are taken. That is entirely a matter for the participating CCGs.

My hon. Friend asked about the cost and burden of the existing arrangements. We all understand the possibility of legal challenge, and there can be complex arrangements that involve organisations going through hoops to ensure that they meet their legal duties, perhaps by going back to their CCGs so that a decision taken in a committee in common may be endorsed. The more complicated those arrangements, however, the greater the risk of legal challenge, and therefore the cost, so simplifying in law the basis by which CCGs and NHS England can come together to make joint decisions, should they want to, improves accountability, makes the system less opaque and reduces the risk of unnecessary costs. I totally agree with my hon. Friend this is not about the burden of localism. Localism is a burden worth carrying; it is not to be avoided. The burden is bureaucratic complexity and the involvement of lawyers—I speak as an ex-lawyer. The more we can keep lawyers out of it, the better, and I am sure many hon. Members would agree.

My hon. Friend made the point that not all consequences may be known at the outset and that things may change, but CCGs can set the terms of reference to provide for that if they choose to. The measure is absolutely permissive; it does not impose anything on anyone.

My right hon. Friend—sorry, my hon. Friend Dr Wollaston. I thought something might have happened as a result of her election to the Chair of the Select Committee, but it will happen in time, I am sure. I am delighted that she supports the measure. She made the perfectly legitimate point that, we ought to be encouraging and facilitating working across boundaries, both of CCGs and of the different organisations involved in health and care, to get the best possible use of the resource available for any local area.

Finally, I repeat that we take on board the concerns of Healthwatch England. We intend to work with that body to ensure maximum accountability for the decisions taken as part of these joint committees.