Bill, Report Stage, Lords, Day 4

Health and Social Care Bill: Report (4th Day) (29 Feb 2012)

Baroness Cumberlege (Conservative)

My Lords, my two amendments have also been grouped with this one. In our debate on 13 December, I explained why I felt so strongly that the evidence from patients gained by the work of local HealthWatch and HealthWatch England should inform local commissioning. I have since had two very helpful meetings with my noble friends Lord Howe and Lady Northover about local HealthWatch and its role. I think that we are moving in the right direction, although there seem to be some outstanding concerns.

Among my serious concerns, and the reason why I brought this amendment back, is that I feel we are not making commissioning robust enough. The process must be founded on evidence. Local HealthWatch offers independent local evidence gathered through the unique statutory function of enter and view. This is evidence straight from the experience of patients lying in wards or sitting in mental health units, as well as those who can fill in surveys. Surveys are useful but do not necessarily reflect the views of the most vulnerable, people who may not be able to fill them in due to frailty, language difficulties or other reasons.

The amendment also relates to the experience from HealthWatch England. If the local HealthWatch has not done work on a particular provider but those in other areas have, that intelligence will be available to a CCG commissioner who is considering giving the contract to a new provider. It has been pointed out to me that Clause 182(6) already requires CCGs to have regard to those reports and recommendations, and that is very valuable. However, this means only that if local HealthWatch produces relevant reports and recommendations, the CCG will have to have regard to them.

It could be that those reports and recommendations arrive at the wrong point in the commissioning cycle or do not arrive at all. Then the CCG will not have an opportunity to have due regard to them. They will be commissioning from providers without evidence from patients of their actual experience, which can come only from local HealthWatch, with its responsibilities to enter and view. The amendment was laid to ensure that that could not happen. It was redrafted in response to my noble friend Lady Northover's characterisation in Committee that if local HealthWatch had an obligation to feed in such evidence, it would be too burdensome for a small organisation composed of volunteers. I am now suggesting that the responsibility should be with the CCG to take evidence from local HealthWatch. It would be helpful if my noble friend could give assurances that CCGs will be guided to seek out from their local HealthWatch evidence of the patient experience to inform their commissioning to the standard set out in new Clause 14Q.

We know that local HealthWatch will have a seat on health and well-being boards, and that will ensure that the knowledge that local HealthWatch has will influence commissioning. Again, I welcome the membership of a lay member. This will have an input into the strategic role of those boards, but how can it give them a say in commissioning when the health and well-being board does not actually commission health services? The board's function is to explore opportunities to integrate services, and this is not the same as deciding whether the outcome of a good patient experience with provider A is better than with provider B. These decisions rest with the CCG under Clauses 140 to 145.

In our debate on 15 December, my noble friend Lord Mawhinney queried whether this amendment was yet another,

"barrier to the commissioning process".-[*Hansard*, 15/12/11; col. 1505.]

My view is that only a provider with something to hide would see this as a barrier. In market terms, this is market research carried out by experienced, impartial, accountable members of the public at no cost to the provider. No provider worth its salt would quibble with such a resource for its quality assurance, and no commissioner trying to commission for the outcome of a better patient experience should ignore this evidence. The best route from patient reality to commissioning theory is through local HealthWatch and the Bill should provide for this.

A report has recently been published on the Forward Look seminars that were held by the public inquiry into Mid Staffordshire NHS Foundation Trust, as has already been mentioned by the noble Lord, Lord Hunt. The inquiry concluded that CCGs need,

"systematic processes for capturing patient experiences",

as well as,

"more robust early warning systems of poor quality care based on qualitative feedback".

My amendment would help to address this. I hope my noble friends will seriously consider the value of this approach and, if they cannot accept the amendment as it stands, seek to achieve it through a government amendment and bring it back at Third Reading.

The amendment is also grouped with Amendment 111, which carries forward the logic of connecting the key evidence-gathering function of local HealthWatch, including its enter and view reports, with commissioning by CCGs, as set out in Amendment 95. Just as the health and well-being board, with its strategic function rooted in the community to which it is democratically accountable, should be consulted about the commissioning plan for local people, so should local HealthWatch. After all, it is the repository of views and experiences garnered from health services. Both perspectives are indispensable to making commissioning work well. I hope my noble friend will look kindly on this simple amendment, too.

Lord Newton of Braintree (Conservative)

This rather curious group also includes the amendments of my noble friend Lady Cumberlege relating to HealthWatch England. I cannot see any problem with them. I support her entirely. It seems to be a no-brainer that if we are to set up a HealthWatch system, people should have to take account of what their local HealthWatches have to say.

Lord Harris of Haringey (Labour)

I want to pick up on Amendments 95 and 111 in the name of the noble Baroness, Lady Cumberlege, and, in particular, the points she made about why she introduced the amendments in this form on the basis of conversations that she had with the government Front Bench and, in particular, the noble Baroness, Lady Northover. She had been led to believe that this would be too burdensome a task for local HealthWatch organisations and that they would be too small to carry out the functions that she talked about.

Baroness Cumberlege (Conservative)

That was not in a private conversation; it came out in Committee and was open to everyone who attended that sitting.

Lord Harris of Haringey (Labour)

That does not alter the point I was about to make, which is that, on the basis of those remarks, it is important to recognise in the Bill that that is the expectation on local HealthWatch organisations. That reflects the growing concern of people outside that, despite the Government's best intentions for how HealthWatch will be organised, those organisations will not be anything like as effective as your Lordships would hope. We hear, for example, that there is widespread concern that the Government will remove the statutory nature of local HealthWatch organisations-we will no doubt come to that in due course. We are told that the Government are indifferent to the consequence of not ring-fencing their finances. The concerns expressed by the noble Baroness, Lady Northover, in Committee, that those organisations may be too small and unable to cope with some of these loads are real. Therefore, it is all more important not only that we provide a framework which enables HealthWatch organisations to be effective but that we make clear in the rest of the legislation the importance of giving a clear statutory role to HealthWatch organisations-in particular, in the vital role of commissioning local services.

Lord Hunt of Kings Heath (Labour)

My Lords, this is a very interesting group of amendments. They do not entirely fit together but all of them raise important points.

I very much support the noble Baroness, Lady Cumberlege, in her comments about HealthWatch. This is my mea culpa moment about the demise of community health councils. It is clear that having a statutory body with the right to be heard and listened to is very important at local level. Of course, I would link the noble Baroness's amendment with the desire for HealthWatch England to be wholly independent of CQC, which is another important ingredient in ensuring that the patient voice is heard as effectively as possible.

Earl Howe (Parliamentary Under Secretary of State (Quality), Health; Conservative)

Amendments 95, 108 and 111, which are similar in effect, would require CCGs to have regard to the advice of local HealthWatch and HealthWatch England, or in the case of Amendment 111 would require local HealthWatch's involvement in developing or revising commissioning plans. HealthWatch England will not advise CCGs directly. Instead its advice will inform the board's commissioning guidance for CCGs. Certainly at the local level, we would expect CCGs to be taking account of local HealthWatch; and, to reassure my noble friend, under Clause 182 CCGs already have to have regard to the views made known by local HealthWatch when exercising functions relating to healthcare services. As my noble friend said, local HealthWatch will also have a key role to play via the health and wellbeing board in assessing local population need-preparing the joint strategy and influencing the commissioning plans of CCGs. Taken together, this represents a robust set of arrangements for the views of patients and the public to feed into local commissioning.

We will use secondary legislation to make detailed provisions as to how CCGs can use these payments, including the circumstances in which they may be able to distribute the whole or part of a payment to individual member practices. That is very important and provides flexibility to adapt any rules or principles governing payments in the light of experience.

We have started discussing the potential contents of these regulations with stakeholders and I can confirm that we will extend these discussions to include a broad spectrum of views, including the NHS, patient groups and professional bodies. I hope I have reassured noble Lords sufficiently to enable them to not press their amendments.