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House of Lords

Tuesday, 11 October 2011.

11 am

Prayers—read by the Lord Bishop of Wakefield.

Health and Social Care Bill

Second Reading

11.06 am

Moved By ***Earl Howe***

That the Bill be read a second time.

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, this is a Bill of profound importance for the quality and delivery of health and care in England, for patients and for all those who care for them. As such it has been, quite rightly, the subject of intense scrutiny, not only in another place, but also more widely. Indeed, the intensity of the spotlight directed at its content over the last few months is borne out by the number of your Lordships who wish to speak today and tomorrow. I look forward to the debate ahead of us.

In approaching this Bill, I believe it is instructive to look backwards to its roots as well as forward to what it seeks to achieve. In opposition, the two coalition parties asked themselves the same simple question: "How can we make the NHS better?". In asking that question we were clear about several things. We were clear that the founding principles of the NHS—that it should be a comprehensive service, free at the point of use, regardless of ability to pay, and funded from general taxation—should remain sacrosanct. We were also clear that we should reject any system that discriminated between rich and poor. The NHS should aspire to the highest standards of service for all our citizens, but in seeking ways to make the health service better, it was necessary to identify the challenges that it faces. What are they?

The first, and most obvious, is rising demand for healthcare from a growing and ageing population and the increase in long-term conditions. The second is the rising expectations of patients about what should be on offer to them from a health service in the 21st century, including new drugs and technologies. The third is the financial challenge—the inexorably rising costs of providing services against an increasingly constrained budget.

Two key principles emerge from this analysis: the need for maximum efficiency in the way the health budget is spent; and the need to make the service patient-centred. For many years, politicians have spoken of the NHS as a patient-centred service, but how can a service be truly patient-centred if decisions about the treatments and pathways of care that are available to patients are taken at several removes from those who know best what the needs of patients are—namely, the patients themselves and the healthcare professionals who look after them?

How can a health service be patient-centred if the measures of its performance overlook what for patients matters most, namely the outcomes that it achieves and the quality of care that patients receive? What of NHS efficiency, when so much of its budget is consumed by layers of administration, when its productivity over the last few years has fallen, and when patients experience poor handovers between different parts of the NHS and between the NHS and social care?

There is a fundamental problem, too, in NHS accountability. The original National Health Service Act 1946 provided for a comprehensive health service, but it did so by employing a simple legal precept—that responsibility for everything that happened in the NHS should lie with the Secretary of State. That may have held good in the 1940s, when the challenges facing the NHS were largely the management of acute short-term conditions, but it does not hold good now. The Secretary of State has for decades delegated his functions for the commissioning and provision of healthcare services to other bodies. The reason for that is simple: managing the range of healthcare needs for our diverse population is now so complex that no one would argue that it is a task best carried out from Whitehall. This has resulted in a vacuum in NHS accountability, with no measures or mechanisms whereby PCTs and trusts can be held locally to account. We in Parliament can only turn to the Secretary of State: he in turn can only give one answer—PCTs and trusts are autonomous organisations, their decisions are taken independently, in accordance with local priorities, and it is not appropriate for these decisions to be subject to interference from the centre. So the fact that the Secretary of State is responsible for making sure that there is an NHS available to all clashes with the fiction—for that is what it is—that he is somehow responsible for all clinical decision-making in the NHS. This results in a poor deal for the person at the centre of things—the patient.

During the last few years, it became clear to politicians of all persuasions that there was another nettle that the NHS had to grasp: the need to improve quality. We know that, measured against accepted benchmarks, the outcomes experienced in the NHS sometimes fail to match up to those achieved in comparable countries. The OECD has reported that if the NHS were to perform as well as the best performing health systems, we could increase life expectancy in the UK by three years.

Towards the end of the previous Government, the noble Lord, Lord Darzi, sounded a clarion call to managers and clinicians around the quality imperative. The focus of the noble Lord's work—to define what quality means and to drive forward that agenda by fostering innovation, transparency, and choice, by strengthening regulation and by encapsulating the rights and legitimate expectations of patients and staff in an NHS constitution—was unarguably right. But his time in office was short. There was much more that still needed doing.

Our plans for the NHS therefore focused on three main themes: accountability, efficiency and quality—keeping at the centre the most important theme of all, the interests of patients. Modernisation of the health

[Earl Howe]
service, we were clear, had to involve a fundamental shift in the balance of power, away from politicians and on to patients themselves through increased choice and information, and on to doctors and health professionals, giving them real budgets and empowering them to use those resources in a cost-effective way to drive up quality. That shift would have two advantages: it would serve to depoliticise the NHS; and it would promote efficiency and quality by making those who take clinical decisions on behalf of their patients responsible for the financial consequences of those decisions. Both GP fundholding in the 1990s and, more recently, practice-based commissioning showed that empowering clinicians directly could improve the quality of care that patients experience. The potential is truly enormous: allowing doctors, nurses, hospital specialists, social services and other professionals the freedom to design care pathways that are integrated, and to commission them on behalf of their patients, will, we firmly believe, transform the quality of care and treatment that the service delivers.

At the same time, the clinicians on whom this greater autonomy is bestowed should be held accountable as never before—not only for their use of public money but also for the outcomes they achieve for patients. Unlike the largely illusory accountability of the present system, we were clear that doctors should be held to account in a transparent way by the patients and the communities whom they serve. Success and failure have to be measured in better and more meaningful ways, by reference to outcomes, not processes. For their part, elected politicians should be held accountable in a dual fashion: first, to Parliament, for the performance of the health service as a whole, defined principally in terms of outcomes; and, in parallel, for directly overseeing and delivering the public health agenda so critical for the long-term health of the nation—an agenda which, too often, has tended to assume a lower priority for government at times when the NHS budget has come under strain.

The fruits of this deliberation were laid out in various Conservative and Liberal Democrat publications from 2006 onwards, including a White Paper, in our manifestos at the last election, the coalition agreement and, finally, a government White Paper from which this Bill directly stems. The democratic mandate for our proposals is absolutely clear.

This brings me to the amendment tabled by the noble Lord, Lord Rea. It is important that we remember what the Labour Party manifesto said on health at the last election:

> "We will continue to press ahead with bold NHS reforms. All hospitals will become Foundation Trusts … Failing hospitals will have their management replaced. We will support an active role for the independent sector working alongside the NHS in the provision of care … Patient power will be increased".

Even Labour accepted at the last election that doing nothing is not an option for the NHS. Many of the principles in this Bill were ones that they wholeheartedly embraced. But the nature of the change must be different. Instead of putting in tiers of management and controlling everything from the centre, we are removing bureaucratic structures so that the front line is empowered as never before to deliver better patient care. This Bill achieves that by means of a better framework which allows power to be devolved from the centre so that innovation is unleashed—

Lord Clinton-Davis: Why was none of this mentioned in the Conservative manifesto at the election?

Earl Howe: I commend the manifesto to the noble Lord because our plans were very clearly set out in it. It allows power to be devolved from the centre so that innovation is unleashed from the bottom up, supported by clear lines of accountability. It is, in fact, the inverse of a topdown reorganisation.

The Bill is long and complex because for the first time in statute it seeks to define the functions and duties of every element in the chain of accountability within a reformed healthcare system, and to join up those functions and duties into a coherent whole. Whereas in the past it has been possible for a Government to change the NHS simply by direction, in the future it will be impossible to do so without recourse to Parliament. Much that was defined in regulations and directions is now to be covered clearly in statute. Daunting as it may seem to some of your Lordships, we were clear that this was an ambition whose realisation was well worth the effort. At the same time as introducing change, it is a Bill which seeks to build on much of the existing and therefore familiar features of the NHS architecture put in place by the previous Administration. Noble lords will know of the Nicholson challenge: to deliver up to £20 billion of savings in the NHS over the next four years, all of which money will be ploughed back into patient care. Savings on this scale are not possible to achieve without system-wide change, and the measures in this Bill are inseparable from that process.

Let me now focus on its content. This Bill is about several things. It is about liberating the NHS and those within it to enable them to work better and more accountably in the interests of patients. It is about streamlining the architecture of the NHS to make it more efficient and transparent. And it is about creating a public health service that is configured to tackle the major challenges to the nation's health and well-being that face us over the years ahead. The key to achieving this, we believe, is a strengthened and more logical spread of accountabilities. Put simply, the Bill provides that the Secretary of State should remain accountable to Parliament, as he has been since 1948, for promoting a comprehensive health service and for the funds voted each year by Parliament for the health budget.

Let me be clear—the Bill does not undermine the Secretary of State's ultimate accountability for the NHS or the responsibility that he carries for a comprehensive service. I am fully aware of concerns raised on this point, and I respectfully refer your Lordships to the response we published yesterday to the Lords Select Committee on the Constitution on this very matter. We are unequivocally clear that the Bill safeguards the Secretary of State's accountability. However, we are willing to listen to and consider the concerns that have been raised and make any necessary amendment to put the matter beyond doubt.

The duty to commission and provide healthcare day to day, which hitherto the Secretary of State has delegated to the NHS, will instead be conferred on NHS bodies directly. Clause 6 proposes that below the Secretary of State there should be a new body, the NHS Commissioning Board, directly responsible for holding and distributing the NHS commissioning budget and for assuming many of the functions now performed by strategic health authorities and patient care trusts, which will be abolished. But the board will not operate without political oversight. The Secretary of State will issue a mandate detailing the outcomes for which the board will be held accountable. The mandate will be subject to public consultation and laid before Parliament, creating a clear line of political accountability. Unlike the current operating framework, the Bill gives the Secretary of State an explicit duty to report on how the board has performed against the mandate. But, as an independent body, the board will be a buffer against the short-term, politically motivated whims of government.

Clause 7 creates clinical commissioning groups as statutory bodies authorised by the board which will commission local healthcare services. CCGs, consisting of groups of GP practices and with doctors in control, will be stewards of the bulk of the NHS commissioning budget and will be held transparently and rigorously to account for the use of those funds against a set of quality and outcome measures. The defining characteristic of CCGs as compared to PCTs will be their clinical ethos. It is doctors and their fellow clinicians, not managers, who know the needs of patients best. By making clinicians financially responsible for the clinical decisions that they take, we will not only drive efficiency but also achieve a step change towards a genuinely patient-centred service.

Real accountability to the patient will be achieved in a number of ways. It will be achieved by empowering patients with information and involving them in decisions around their care. But it will also be achieved by empowering local groups of patient representatives to be involved in how services are commissioned, provided and scrutinised. Clauses 178 to 186 propose the creation of HealthWatch. Local HealthWatch will be based on the existing local involvement networks, or LINks, but with added clout. Funded through local authorities, they will act as the independent eyes, ears and voice of patients and service users in a local area. At the national level, a new body, HealthWatch England, will be established to support local HealthWatch and to act as the national care watchdog wherever quality of care is called into serious question. By making HealthWatch England a committee of the Care Quality Commission, as is proposed in the Bill, we will enable the voice of patients and the public to be heard at the very heart of health and social care regulation.

But liberating the NHS goes further. It means enabling the governors of foundation trusts, who represent the public, patients and staff, to exercise more meaningful influence over strategic decisions made by their trust boards. It means freeing foundation trusts from the private income cap; a constraint which they repeatedly tell us is arbitrary and unnecessary, and whose removal will enable them—without jeopardising their NHS focus—to generate income which can be deployed for the benefit of NHS patients. Clauses 148 to 177 cover these proposals. Noble lords will recall the debate we had on this subject two years ago.

In developing healthcare provision, the previous Government began to champion the cause of patient choice as a driver of quality, and in doing so moved us in the direction of a more plural service with the introduction of independent sector treatment centres, social enterprises and charities operating alongside mainstream NHS providers. We have long agreed that this was the right direction of travel. Competition and choice will no doubt prove a major theme in some of our later debates on the Bill, but let me say for now that we are absolutely clear from past evidence that where competition can operate to improve the service on offer to patients, or to address a need that the NHS fails to meet, we should let the system facilitate it. However, competition only has a place when it is clearly and unequivocally in the interests of patients.

This is where we were critical of one aspect of the previous Government's policies. The playing field was levelled against the NHS. ISTCs were given guarantees and price subsidies that were not available to public sector providers. That is why we want to ensure that all providers of healthcare operate to the same clear rules. This, in turn, necessitates an independent body capable of holding the ring. That body, we propose, should be Monitor in its new guise as a sector-specific regulator for the health service, with functions and duties framed to enable it to bear down on unfair competition, conflicts of interest and unsustainable pricing. It will operate in accordance with the principles and rules for co-operation and competition, which were introduced by the previous Administration.

For a long time now, the idea of a local democratic mandate for healthcare provision has been a pipedream of many. For the first time, this Bill imposes duties on local authorities that will see the creation of health and well-being boards, bodies charged with assessing and addressing the health and social care needs of a local area. This represents a huge opportunity for improving the commissioning of health and social care. Health and well-being boards will consist of, as a minimum, representatives from clinical commissioning groups, social care, public health and patient groups including local healthwatch, plus elected representatives. They will provide a forum for joined-up decision-making on service configuration and local priorities. Joint health and well-being strategies will not simply inform clinical commissioning in a local area, CCGs will also be required to have regard to them when preparing their commissioning plans, with safeguards in place should they fail to do so. The democratic underpinning this gives to service provision is a major and exciting change.

At the same time, the Government's clear focus on public health will usher in a new public health architecture. At a local level, for the first time since 1974, local authorities will become the hubs for commissioning and delivering public health services, led by directors of public health and supported by a ring-fenced budget. At the centre, under the direct auspices of the Secretary of State, a new executive agency, Public Health England, will bring together health protection functions currently

[Earl Howe]
distributed between a number of different organisations. In driving forward public health strategies at a national level, it will inform and support local authorities in their work, thus ensuring a joined-up system. We believe it is of vital importance that public health should receive the emphasis due to it, if we are to tackle the long-term challenges to the nation's health and well-being that currently face us.

Alongside this, we will modernise and streamline the Department of Health's arm's-length bodies. The Bill abolishes bodies that are no longer required, thus releasing more money to the front line. At the same time, NICE and the NHS Information Centre will have their future secured by being established in primary legislation for the first time.

The changes we have set out will be introduced in measured stages over a period of years, and our plans for transition will ensure that the health service is well prepared; for example, no clinical commissioning group will be authorised to take on any part of the commissioning budget until it is ready and willing to so; Monitor will continue to have transitional intervention powers over all foundation trusts until 2016 to maintain high standards of governance during the transition; and to avoid instability, there will be a careful transition process on education and training.

In framing the provisions of this Bill, Ministers have talked and listened to a great many people; not only before the election but since, with a public engagement on our White Paper in 2010 and, in the spring of this year, the very productive two-month listening exercise. Throughout this time we have encountered consistent and widespread agreement for the key principles underpinning our policies; in particular, since the listening exercise, a shared view among professionals about the way those principles should be put into practice. At the same time, reform of the NHS is seen not just as an option but as absolutely essential for its future.

In addition to this consultation and engagement, this Bill has also undergone significant scrutiny in the other place. The Bill's first Committee stage lasted 28 sittings—longer than any Bill in nine years. Following the Future Forum's report, the Bill was recommitted for a further 12 sittings. The Bill was therefore scrutinised over more sittings in the other place—40 in total—than any other Public Bill in the whole period from 1997 to 2010. I direct that point in particular to the noble Lord, Lord Rea.

I conclude with a brief word about the Motion tabled by the noble Lord, Lord Owen, which I shall speak to in detail when I wind up the debate. Suffice it to say for now that while I fully recognise the strength of his concerns, I regard the proposal he has made as posing an unacceptable risk to the passage of this Bill and hence to the Government's programme for the health service. He is proposing an unusual process. The only basis on which such a process might be workable would be with the prior reassurance, for the Government, of a strict time limit on the Bill's Committee stage as a whole. Regrettably, I was unable to reach agreement with the noble Lord that this was a reasonable basis on which to proceed. I therefore do not think that his Motion should be supported.

The case for change is clear and compelling, and I am personally in no doubt that the changes set out in this Bill are right for our NHS and—more importantly—right for patients. I hope very much that your Lordships, in reserving your powers to scrutinise the detail of the Bill with your usual care, will wish to endorse the ideas and the vision that it presents. This is a Bill with but a single purpose: to deliver, for the long term, a sustainable NHS, true to its founding principles. It is on that basis that I am proud to commend the Bill to the House, and I beg to move.

Amendment to the Motion

Moved by ***Lord Rea***

As an amendment to the Motion that the Bill be now read a second time, to leave out from "that" to the end and insert "this House declines to give the Bill a second reading, in the light of the statement in the Coalition Agreement that 'we will stop the top-down reorganisations of the NHS that have got in the way of patient care'."

11.32 am

Lord Rea: My Lords, the noble Earl, as always, gave us a carefully crafted and elegant speech, much of which I agreed with. However, I will start by raising one point. In the letter he sent to Peers last week, he repeated verbatim the words in the White Paper that claim that Britain's health record is worse than that of other EU countries, especially France. It appears that he has not read the paper in the *British Medical Journal* by John Appleby, the chief economist at the King's Fund, which demonstrates that these claims are false, that Britain's health is improving faster than that of any other country in the EU, and that we will shortly overtake France, whose health expenditure is far greater as a percentage of GDP than ours.

I will explain why I put down my amendment. I did not do this lightly. I realise that it is very unusual for your Lordships' House to oppose a Bill that has passed all its stages in another place. However, the Library tells me that it has happened 13 times since 1970—about once every three years. The Salisbury-Addison convention aims, of course, to ensure the primacy of the House of Commons. The convention that has evolved is that in the House of Lords, a manifesto Bill is accorded a Second Reading and is not subject to wrecking amendments. Over the years, the convention has been discussed at length and in depth. In the case of a coalition Government without a joint manifesto—as we have now—the clearest indicator of the policy to be followed lies in the coalition agreement.

The noble Lord, Lord Strathclyde, said on 20 January in a debate on coalition government secured by the noble Baroness, Lady Symons:

"The Salisbury convention applies to manifesto Bills, but this Government did not contest the election as a single party under a single manifesto. However, the Government … were formed and are sustained on the basis of the confidence of the House of Commons. This confidence has been secured on the basis of a programme set out in the coalition agreement".—[*Official Report*, 20/1/11; col. 600.]

That agreement contains the words I included in my amendment. I will repeat them:

"We will stop the top-down reorganisations of the NHS that have got in the way of patient care".

The agreement contains no words suggesting that this enormous Bill was in the pipeline. Nor was it mentioned in either the Conservative or Liberal Democrat manifestos.

An indication of Conservative policy that reached far more people than the number who read the 110-page manifesto was David Cameron's widely reported statement made to the Royal College of Pathologists in November 2009. He said:

"It's true, with the Conservatives there will be no more of the tiresome, meddlesome, top-down re-structures that have dominated the last decade of the NHS".

Instead of having a Bill that was in a manifesto, we have one that was expressly ruled out by the words of David Cameron's speech, and subsequently by the coalition agreement. So the Salisbury convention, if relevant here, applies in a reverse direction. If we allow the Bill to pass, we will be voting directly against the words of the coalition agreement.

It seems that there was deliberate concealment of what was planned. The Bill—or something like it—must have been in gestation for months if not years before the election. Michael Portillo said, on Andrew Neil's late-evening politics programme, that it was not put into the Conservative manifesto because it would have lost the election, as the NHS is almost a religion in Britain. That implies that it had to be slipped in by the back door. How patronising that is. It says that we, the Conservatives, know what people need better than they do. In fact, it is possible to trace the development of the ideas behind the Bill in Conservative think tanks dating back more than 20 years.

What is proposed is probably the most far-reaching reorganisation of the NHS ever undertaken. It now has 320 clauses and 22 schedules, in two volumes, with 353 pages. It is longer than the Bill that created the National Health Service in 1946.

The White Paper, *Equity and Excellence: Liberating the NHS,* which is full of euphemistic phrases that everybody can agree with, did not prepare us for the Bill. Neither the White Paper nor the Bill expressed clearly the underlying intention of the Bill, which many think is to open the door wider—it is already ajar—for the market and the independent sector to play a bigger role in the National Health Service. The process was made possible first by the compulsory tendering of domestic services in the 1980s, followed by the introduction in 1990 of the internal market, which was retained by the Labour Government. They brought in the private sector to provide some clinical services, reduce waiting lists and provide certain other services.

Many have argued, with evidence and from experience, that this could have been done within the National Health Service. Short-term political gain has resulted in us now reaping the whirlwind of greatly increased costs, nowhere more so than in the private finance initiative, referred to by the BMA as "perfidious financial idiocy". This assessment has now been confirmed by the Public Accounts Committee. Since 1990, the proportion of the National Health Service budget devoted to administrative costs has risen from 5 to 14 per cent, according to the Centre for Health Economics at York University. That is an extra £10 billion a year.

This Bill, despite its stated effects of saving administrative costs, is likely to increase them further. The Government say that the financial difficulties of the NHS are such that the Bill must be enacted quickly. However, there is no evidence that the changes suggested by the Bill will reduce costs—rather the reverse. A recent research review by a team at the London School of Hygiene and Tropical Medicine showed that competition in the health sector, far from improving National Health Service costs and clinical outcomes, had the reverse effect.

Clinicians in the proposed clinical commissioning groups will find that commissioning is a highly complex task. They will need the assistance of experienced administrators, statisticians and public health specialists, as well as competent clerical support. These experts are already being lined up. They are not experienced PCT staff who are available without extra expense, and who are now anxious about their future, as David Nicholson pointed out yesterday. They are mainly from commercial health companies. A freedom of information request revealed a list of 40 organisations, most of them private, which have been invited to bid for contracts to train GP consortia, now clinical commissioning groups. For this role, in London alone, £7 million has been allocated for the initial phase, taken from funds originally allocated for postgraduate education.

It will be argued that changes on the ground are too far down the road to reverse. However, PCTs are still in existence and could be re-established in a leaner and more efficient form, with enhanced clinical membership, perhaps bringing in pathfinder groups. A similar suggestion has just been made by Andy Burnham, our new shadow Health Minister, in a letter to Andrew Lansley. Many of us would like to know the Government's justification for starting to implement the changes before the Bill has passed through Parliament. And inquiry might find this to be unconstitutional, if not illegal. The noble Baroness, Lady Williams of Crosby, suggested as much in a powerful article in the *British Medical Journal* this week.

In conclusion, I ask Liberal Democrat and other government Peers who are unhappy with the Bill to seriously consider voting for my amendment, or at least abstaining if a Division is called. The Bill is not in the coalition agreement, and it is always open to coalition parties to disagree on some issues. The coalition will not fall if the Bill is lost. I assure the noble Lord, Lord Owen, and other Peers, that if my amendment is not carried I will certainly vote for his amendment, and I urge all Peers to do so. Of course, I know that I can count on the support of my noble friends.

There are many aspects of the Bill that I have not covered. However, I am sure that others among the many speakers will fill in the gaps. I shall be guided by the course of the debate on whether to divide the House. However, I know that many thousands of people throughout the country—not only health professionals by any means—oppose the Bill and want the House to reject it. The large, peaceful demonstration

[LORD REA]
on Westminster Bridge on Sunday was an example of this. They will be bitterly disappointed with the House if I do not call for a vote, and I will not ignore them.

Baroness Anelay of St Johns: My Lords, it may be helpful to the House if at this stage I give some guidance on an advisory speaking time. There are 100 speakers signed up for the whole of the debate, including the Front Bench spokespersons. If Back-Bench contributions were kept hereafter to eight minutes, the House should today be able to rise at about 11.30 pm. For the avoidance of doubt, perhaps I may emphasise that the next speaker is the noble Baroness, Lady Thornton, who is a Front Bench spokesperson for the Opposition. Therefore, my advice is for all speakers subsequent to her.

11.45 am

Baroness Thornton: My Lords, along with everyone in the House, I thank the Minister for his most competent and coherent introduction to the Health and Social Care Bill 2011. The Labour Benches have a great team dedicated to working on this Bill. It includes my noble friends Lord Hunt, Lord Beecham, Lady Royall and Lady Wheeler; our new Whip, my noble friend Lord Collins, who recently retired as the general secretary of the Labour Party and joins us as our junior member of the health team; and, of course, a galaxy of experience behind us.

I became so desperate to see this legislation that I even got involved with the Localism Bill in the summer, so desperate was I to be doing something. Long awaited, the delayed Bill we are considering today is in its fourth version so far. Indeed, it may not be the last. The first was definitely the Conservative version. It was prepared before the election based on the ideology of markets and regulation. It is now a much more complex Bill but the core intent remains the same. This Bill, with its 303 clauses and 24 schedules, creates a framework that will fundamentally change the nature of the NHS. It will change the NHS from a health system into a competitive market. It will turn patients into consumers and patient choice into shopping. Most crucially, it will turn our healthcare into a traded commodity.

Therefore, I start with a fundamental and simple point. People did not expect, did not vote for and do not want these changes. The Government were not elected to do this. They do not have the electorate's mandate. I know we will hear arguments about whether or not this Bill is a mere continuation of the work of my former Government. I assure noble Lords from the outset that this is a specious argument, which I urge them to put aside. Our reforms were in our manifesto. They helped to improve and strengthen the NHS. They most certainly were not this Bill.

This Bill was not mentioned in anyone's manifesto; nor was it in the coalition agreement. As for the democratic mandate mentioned by the Minister, top-down reorganisation, which is what the Prime Minister said, does not seem to be a mandate. One can scour the manifestos of the Conservative Party and the Liberal Democrat Party, and the coalition agreement, for anything that suggests a fundamental change to the powers of the Secretary of State for Health. Nothing suggested wholesale dismantling of the structures of the NHS; nothing about the biggest quango in the world being created, the NHS Commissioning Board; nothing about the intention to allow £60 billion of taxpayers' money to be spent by GPs, originally on their own and now through clinical commissioning; nothing about the creation of a huge bureaucratic economic regulator, the new Monitor; and nothing about many other parts of this Bill, some of which is good and some less so. There is no mandate for this Bill. That is a serious constitutional issue for this House, which is signalled to us by, for example, the Constitution Committee report.

In the context of the most draconian changes for 60 years, the least we could have expected was a raft of analysis and evidence that would form a convincing and arguable case for the direct benefits of these changes to patients. If the evidence exists—I would say that it does not—it has manifestly failed to convince those who work in our NHS, those who study our NHS and certainly those who use it: so, no mandate, no evidence and no support. In addition to that, there has been one of the worst impact assessments that most experts have ever seen, showing no cost benefits. I suggest that this is not much of a basis for a change programme, which, to quote David Nicholson, is so large that it can be seen from space.

It is a sad day for this House and for Parliament that we are being urged to expedite this Bill. As informed commentators keep telling us, the state of disorganisation in the NHS is past the point of no return. Indeed, the Minister circulated a letter minutes before this debate started in which the last paragraph points to and emphasises the need for us to get on with this rather than the need for us to scrutinise this Bill.

There has been a breathtaking disregard for the democratic process. The reforms are being implemented in such a way that there is now paralysis, uncertainty and lack of leadership in the system. This has been inflicted on the NHS by this Government. Is it too late for a fresh look? I do not think so. I urge noble Lords not to be panicked, bullied or browbeaten. Our job is to scrutinise and improve this Bill, because it is certainly the most significant legislation that we are going to see in the whole of this Parliament.

On these Benches, we take this responsibility very seriously—indeed, I think that all noble Lords feel this responsibility—because we must not fail. All eyes are on us. If the Bill proceeds into Committee, these Benches will not delay this Bill in its passage through the House. I have promised the Minister this. In return, the Government must make as much time available as noble Lords need to give this huge and complex Bill the scrutiny that it deserves. The public and the NHS would not understand if we did anything less.

I pay tribute to the noble Baroness, Lady Williams, and others, such as Evan Harris, for their steadfast campaign and I hope that we can work together to improve this Bill. I promise that these Benches will be here to support sensible amendments to this Bill from wherever they come and I hope that noble Lords will do the same.

Perhaps I might gently remind my Liberal Democrat friends that for many years the NHS has been a toxic political issue for the Conservative Party and it never was for them. In fact, the Liberal Party was in at the birth of the NHS: you were part of its genesis. I would just ask: why would you put that legacy and that history in such jeopardy? As for the Conservative Party, people wanted to believe David Cameron when he promised before the election to protect the NHS. He promised to guarantee a real rise in funding and to stop top-down NHS reorganisation. I put it to noble Lords that every one of his promises is now being broken.

At a time of austerity, the NHS needs co-operation, collaboration and integration, not experiments with the extension of competition. So we are keen to scrutinise this Bill: we support the greater involvement of clinicians in commissioning; we support the devolvement of public health to local authorities with the right safeguards and financial support, and independence at a national level; and we support the creation of health and well-being boards and local accountability. We believe that the Bill needs to enhance the patient's voice because we think that that is very inadequate at the moment. We believe that accountability and transparency need to be addressed from top to bottom of this Bill.

In addition, we believe there are matters concerning mental health, children's safety and well-being, training and workforce planning, research and many other issues that will be raised by noble Lords across this House, which will need plenty of time in which to be debated and given the scrutiny that they deserve.

The wider context of this, of course, is the need for the NHS to deliver the Nicholson challenge and find the £20 billion of efficiency savings. We on these Benches believe that that is a priority and is enough in itself. Our concerns with this Bill are many and serious but the core of the Bill around regulation and the failure regime did not receive proper scrutiny in the other place. Indeed, the failure regime received no scrutiny whatever because it was introduced too late. We will be seeking major changes to Part 3, which we regard as dangerous as well as unnecessarily complex, bureaucratic and expensive. We do not support making our NHS into a regulated market, as advocated by some. Whatever the merits of competition and quasi-markets—we will hear a lot about these during the course of the Bill—they cannot be the basis for the delivery of healthcare. Indeed, there is a role for regulation, but the role and nature of the regulator has to be a lot clearer than it is in this Bill at the moment. I am giving noble Lords a very rapid summary of our major concerns and the areas of the Bill which we think need attention.

I now wish to address the procedural and constitutional challenges posed by the Bill. I would like to be very clear to the House: my right honourable friend Andy Burnham made a serious offer to the Secretary of State over the weekend. He asked the Government to withdraw the Bill and committed Labour to co-operating with the Government to implement the clinical commissioning agenda using existing powers, and doing it as quickly as possible. I repeat that offer to the Minister now. However, frankly the omens do not look good.

My party will support the amendment of my noble friend Lord Rea not to proceed any further with the Bill. We invite all those who love their NHS to join us. We do this with a heavy heart because it is this House's job to scrutinise and improve legislation. However, we believe we have no option because there is no doubt that there is an overwhelming call for us to stop the Bill from the royal colleges, the professions, doctors, nurses, thousands of health workers, patients and, indeed, non-patients. However, there is an alternative before us today, and we think this offers a way forward if the Bill is not withdrawn or stopped. It is an alternative offered by the amendment in the name of the noble Lord, Lord Owen. The idea that we can have double the scrutiny going on at the same time is very attractive. We believe that it will expedite the process of scrutiny and we urge the Minister to accept this proposal. We know from previous experience that issues referred to a Select Committee help the House enormously in taking decisions.

Why did 100 noble Lords want to speak in this debate? Why did the noble Lord, Lord Owen, feel moved to put a significant amount of his time over the summer into working out a constructive way to maximise the scrutiny of the Bill? Why has the noble Baroness, Lady Williams, spent an enormous amount of her time since the spring trying to work out a way forward for the Bill? Why have dozens of noble Lords attended seminars and briefings since March better to understand this Bill? Why do we think thousands of people have written letters and sent e-mails to Peers across the House expressing their concern about the future of the NHS? Indeed, I pay tribute to the GPs, clinicians, nurses, midwives, physios and other ancillary therapists, mental health workers, care workers, trade unions, patient groups and health charities for the time and attention they have given to the detail in the Bill. The majority still do not like it. All of this has happened because our NHS is precious to every family and every person in the land, whether or not we use it. Everyone knows that whatever happens to them, wherever they are and however serious it may be, they can get healthcare. This is possible because we pay for it together and it is part of the social fabric of our nation. The NHS, in Bagehot's terms, has a dignified as well as an efficient side and a specific role in the psyche of the nation as a symbolic guarantor of fundamental decencies. Any prospective reformer would have to respect those. I suggest that Andrew Lansley has not done so.

Our NHS was built on the principles of co-operation and integration as a genuinely national system with a properly accountable Secretary of State answerable to Parliament—a system working for the benefit of patients. This is where I end because the only real test of these reforms is their impact on patients. We are good in this House at hearing patients' experiences and acting on them. We will have to listen very carefully indeed in the coming months. There is huge expertise in this House: medical, legal, organisational, charitable, and, often the most important, a great deal of common sense and practical experience. We will need to bring every bit of this wealth of talent to bear on this Health and Social Care Bill. I look forward to working with noble Lords across the House and with the Minister in the coming months.

11.59 am

Baroness Jolly: My Lords, we have heard well-argued speeches, as we would expect, from my noble friend Lord Howe and from the noble Baroness, Lady Symons, the Opposition Front Bench health spokesman—

Noble Lords: Thornton!

Baroness Jolly: Apologies to the noble Baroness, Lady Thornton. I have that name written down but the wrong one came out. They have provoked thought. At the debate on the Future Forum, called by the noble Baroness, Lady Wheeler, before the conference recess, I flagged up many of my concerns with this Bill, but time did not allow me to share them all. I fear that I will have the same problem today, but I am sure that my noble friends on the Benches behind me will be happy to fill in any gaps I may leave; in particular, areas of inequality, mental health, and the role of Monitor in competition and integration.

For the record, my areas of concern which I flagged up in that debate were the accountability of the Secretary of State—this needs to be right from the beginning and completely unambiguous, and he or she needs to be hands off and responsible at one and the same time; the need for clarity within the local government and clinical commissioning groups and democratic accountability; the role and status of the director of public health within local government, which will be critical and will need work; and the need for clarity about education, training and workforce development within local government.

I am delighted that this Bill is designed to promote integrated care—acute and community services working as one with social care. The patient and carer must be totally woven into these new networks and clinical senates. In future, patients and carers should not have their care packages worked out in isolation.

As I was working out how I was going to come up with this speech, I realised that it is nine months to the day since I was introduced to this House. In the maiden speech I made two days later, I told the House about my time on various NHS trust boards. From that time, I offer your Lordships an example of why the Secretary of State must be hands off.

We needed extra capacity to deal with cataracts in my area and made the appropriate arrangements through a local hospital. Before this could be finalised, we had the project pulled and replaced by a new treatment centre, run by the private sector, which would also offer terminations and endoscopic diagnosis. This would be based in a new build—not particularly where patients wanted to go—and we were given patient target numbers not only to meet but to pay for whether they were met or not. We did not need all that provision and it was in the wrong place. We respectfully told the powers that be that we were happy with our original solution, thank you. We were then told, in very blunt language, that it would happen with or without our decision, and that if our board did not approve it, another would be found that would. So that is a result of the Secretary of State with a power to intervene. Fortunately, under this Bill, this proposal would come before Monitor and the privately run hospital would be deemed not to be in the best interests of local patients and it would not proceed.

I must have sat through hundreds of board meetings, not to mention audit committees, clinical governance groups and remuneration committees. They were all about the structure of the NHS. There were times, as we discussed systems and processes, that the patient never got a mention and was certainly rarely there at the table.

By their own admission, the Government want to put the patient at the centre of the NHS—"No decision about me without me" is a laudable and catchy strap line. We welcome that, but I fear that at times this patient is still sidelined. Care will have to be taken to embed a serious culture change.

I fear that this Bill, as it stands, has areas which are about process; engineering the system for desired outputs and outcomes while Mrs Smith or Mr Patel is forgotten. Just how much within the Bill needs looking at again from the perspective of individual care and not making the individual fit what is being designed?

There are three distinct areas for patient involvement. First, at the time of a consultation with a professional they need to be involved in their care plan and look at any options. There is evidence—there has been a lot said today about evidence—that 75 per cent want involvement and that if they become involved they do better. Incidentally, that goes some way towards reducing health inequalities. This needs to start upstream and it needs to be built into commissioning.

Secondly, we can look at a patient as an expert patient, offering insight and refection in how their experiences can help the care of others, as can patient organisations. Again this needs to be built into the commissioning process, into senates and into local networks. Finally, as a member of a local healthwatch or HealthWatch England, these replaced the old LINks groups and, as yet, do not have a sufficiently robust structure with the ability to challenge. Here I disagree with the Minister. They do need more clout.

We are faced with two amendments to the Motion, one tabled by the noble Lord, Lord Rea, and the other by the noble Lord, Lord Owen. I will take them separately and explain why I am not supporting either. First, on that of the noble Lord, Lord Rea, as a Liberal Democrat I know only too well that many areas of this Bill, for the most part, fall outside the coalition agreement, which I voted to support in May 2010. In fact, it drives a coach and horses through the agreement. This leaves us the opportunity on these Benches to revert to our manifesto and policy document in deciding amendments. When I arrived in this place, the Bill was already printed and starting its passage through the other place. History will tell us whether there was a Blue Peter here's-one-I-prepared-earlier moment and who the main players were. I expect it to be silent on the matter of wire coat hangers, cereal packets, and sticky-backed plastic.

It is the Government's Bill and it is not without fault. One of my early lessons here was that it is our role to improve and not to reject Bills. We need to take those faults and work to take them out. As a junior member of the coalition, I have found Ministers'

doors have been open, and there has been a willingness to listen and engage. I welcome the invitation of the noble Baroness, Lady Symons, to work together in the interests of the public and the NHS.

Noble Lords: Thornton.

Baroness Jolly: Thornton—I beg your pardon. It is the first time I have made that mistake. You know who I mean. I apologise to the noble Baroness, Lady Thornton. I welcome your invitation.

Next, the amendment of the noble Lord, Lord Owen, is more nuanced, but puzzling. The noble Lord calls for those issues raised by the Constitution Committee report dealing with powers and responsibilities of the Secretary of State to be extracted and given to a Select Committee to work on while the remainder remain within the House in Committee in this Chamber. Thanks to the hard work of the noble Baroness, Lady Thornton—I have it right—in pulling together a really well-attended series of fascinating seminars about all aspects of this Bill, followed by a similar series arranged by noble Earl, Lord Howe, the opportunity to question think tanks, Royal Colleges and senior civil servants was made available to all Peers and was taken up by many. Peers are well informed about this Bill and are able to deliberate, scrutinise and amend in the usual way—in a Committee of the whole House. This is the general custom and I see no reason to do otherwise.

I ask my noble Lords to reject both amendments. Let us get on with doing what we are praised for doing worldwide; scrutinising difficult and complex legislation as a House, with a view to producing a better, workable Bill.

12.08 pm

Lord Birt: My Lords, there is probably no one in your Lordships' House who does not have cause to be grateful for what the NHS has done for them or their families. Recently, as my own parents entered the final chapter of their long lives, I witnessed at close hand the expertise, dedication and sheer good cheer of the care that they were fortunate enough to receive.

However, I also saw the many ways in which the NHS could improve. That is no surprise. All organisations can improve. All need to adapt and develop in the light of the continuously shifting circumstances they encounter. Technology will offer radical opportunities for improving effectiveness and efficiency. Science will uncover previously unthought-of ways of addressing old problems. Citizens and consumers will make new and different demands. The private sector offers examples of organisations of every size that have transformed their effectiveness, often at times of great adversity. They have had to develop new capabilities, to create new structures, to define a new focus or accountability.

The test of all health reform is: will the proposal create better health outcomes? Can the UK match or improve on best international practice? Will the reform enhance patient choice, experience and convenience? Will GP surgeries be encouraged to be open when a population largely in work is most free to visit, furthermore relieving an unnecessary burden on A&E? Will the reform promote efficiency, and thus optimise the health outcomes for any given level of available resource? Will it foster and reward innovation? Will it enable a diversity of providers, competing on quality, on clinical effectiveness, and on patient satisfaction, as well as efficiency of provision? As treatment possibilities change, will the new system be flexible enough to enable the supply of the relevant service to be lodged at the appropriate level, whether local, regional or national? The recent welcome improvement of stroke care in London is a case in point. Will the reform encourage greater collaboration and, where appropriate, integration?

My best understanding of the reforms before us today is that they form a continuum, building on the modernisation process begun under John Major, and—with stutters and starts—continued under Tony Blair. Here I declare an interest as I was the Prime Minister's strategy adviser at the time. Taken together, these reforms are comprehensive and coherent and should address the challenges I have just outlined. They simplify the architecture of the whole health system and lodge accountability for who is responsible for what at every level. In particular, I welcome that they define the role of the Secretary of State not as Minister for the "Today" programme, but as holding ultimate responsibility for the strategic direction and overall effectiveness of the whole system.

These reforms create an arm's-length commissioning board with the responsibility and the powers to ensure that commissioning is effective. They maintain a system of advice and supervision to promulgate best practice and to safeguard the quality of health service providers. They bring greater openness and transparency, and they allow greater scrutiny of both the system's marching orders—the three-year mandate—and of the performance of the system overall. They set up, in Monitor, a regulator which can set tariffs to promote best practice and guard against anti-competitive behaviour of any kind. They introduce a failure regime which will maintain essential services for patients while enabling an orderly transition to a more effective alternative. Most welcome of all, they lodge the prime spending responsibility at the front line with GPs and other clinicians, who are far better placed than bureaucrats to make the very difficult trade-offs, and to optimise patient welfare.

These reforms will not be the last word. The NHS will—must—continue to adapt and to change. No doubt the Bill can be further strengthened in its passage through this House. In the round, these measures seem to be another welcome step on the way to the ever more effective NHS that all here desire and want to see.

12.14 pm

The Lord Bishop of Bristol: My Lords, what is clear from the vast volume of correspondence that has arrived in my office in recent weeks is that there is something deep in the psyche of our nation which is extremely anxious about the reforms to the NHS being proposed by the Government in this Bill. Some of that concern is based on a misunderstanding of what is being proposed, but much of it is, in my view, substantive criticism and, significantly, often being voiced by organisations that represent thousands of

[The Lord Bishop of Bristol]
healthcare professionals. The Government have argued with force that reform is necessary given that the projected costs of the health service going forward are not sustainable. In varying degrees, this observation carries some support. Their stated aim to improve the quality of care is to be welcomed.

The Government made a number of welcome changes to the Bill following the first report of the NHS Future Forum in June 2011. Those changes went some way to addressing concerns, particularly with regard to the composition and remit of commissioning groups, and to the expansion of competition within the NHS. Some outstanding issues, however, still remain to be resolved.

First, despite the reassurances given by the Minister, I wish to make a foundational point which I hope the noble Earl will take into account in his further deliberations on this matter. The Health and Social Care Bill as is runs the risk, I believe, of breaking the obligation of the Government to take responsibility for healthcare in the nation. This is not merely a matter to be judged on the grounds of efficiency or effectiveness, although both are important and, of course, as yet there is no evidence that the proposed changes set out in the Bill will promote either. Rather, the Government's responsibility for the welfare of the people, including healthcare, is part of the fundamental legitimisation of the state, and a main reason why individuals should subordinate themselves, within limits, to the state. Is it too much to say that a state which withdraws from the responsibility to deliver the welfare of the people loses its legitimate claim on the lives of its citizens? There can be no more fundamental aspect of welfare than healthcare. For this reason, as well as for reasons of practical accountability, it is absolutely essential that the Secretary of State for Health retains final executive authority for the delivery of healthcare and does not relinquish ultimate responsibility either to Monitor or to the NHS Commissioning Board.

Moving on to the NHS Constitution, the Bill now places an onus on both the NHS Commissioning Board and the clinical commissioning groups, formerly the GP consortia,

"to take active steps to promote the Constitution".

The NHS Constitution contains seven key principles which include providing a "comprehensive service to all", and providing services that,

"reflect the needs and preferences of patients, their families and their carers".

This new role of promoting the NHS Constitution through commissioning strategies and decisions is to be welcomed. It means that the commissioning of services cannot be based solely on a traditional medical model of care. The whole needs of patients and others must be met through the provision of comprehensive services. This includes, among other things, meeting their spiritual needs. For many people, spiritual needs may be met only through the provision of religious care. Chaplains are uniquely trained and qualified to provide both religious and spiritual care and, as such, it ought to be explicitly understood that both commissioners and providers should take into account the need for spiritual care where appropriate.

Similar consideration ought also to be given to ensuring that the range of services provided by allied health professionals are maintained and protected, and that the viability of small specialist departments is not compromised through financially driven reorganisation. In a proposed environment of competition, there is a real risk that providers may compromise the quality of their services in order to obtain a contract. It is essential that the requirements of the NHS Constitution are rigorously adhered to by both commissioners and providers in order to minimise this risk.

Concern with regard to providers cutting corners in order to obtain contracts extends also to the nursing profession. Both the Queen's Nursing Institute and the Royal College of Nursing have noted the real risk of underskilled staff being used by providers in the community and in care homes, partly to enable their bids to be competitive. Commissioning bodies, in order to provide adequate services, need to understand the breadth and quality of nursing care required to meet patient and carer needs.

I have an anxiety about the complexity of the NHS structures that will be created by the Bill. Part of the rationale for reconfiguring the NHS was to simplify its structures and management. At present, the Bill envisages a health service that has a much more complex structure and a greater array of interlocking organisations than before. In addition to the Secretary of State, whose function is to become one of oversight rather than of direct involvement, the new look NHS will encompass the NHS Commissioning Board, clinical commissioning groups, health and well-being boards, Monitor, the Care Quality Commission, the National Institute for Health and Care Excellence, HealthWatch England, Public Health England, clinical networks and clinical senates. In addition, local authorities will have direct input into both public health and the proposed health and well-being boards.

The main problem with the proposed structure is that it may render it difficult to determine precisely where, in practice, decision-making powers lie. The proposed remits of these organisations not only interlock, but frequently overlap. There is a twin danger of the NHS Commissioning Board retaining too much control so that the clinical commissioning groups and health and well-being boards are stripped of any real decision-making powers, or conversely of the checks and balances within the system becoming so cumbersome that decision-making becomes frustratingly difficult to achieve. For example, local authorities and health and well-being boards will, on occasion, be at variance with clinical commissioning groups. The proposed mechanisms for resolving such disputes are complex and may result in the NHS Commissioning Board being drawn into a level of micromanagement that it never envisaged. There is a real danger that the complexity of the proposed structures could lead to a paralysis in decision-making that would be reflected in compromised patient and client safety and care.

I want to make a further point about clinical commissioning groups. The change from GP consortia to clinical commissioning groups reflects the need for the involvement of other health professionals as well as patients and clients in the commissioning of services.

The proposed establishment of governing bodies within each clinical commissioning group is to be welcomed both for governance and transparency reasons. So, too, is the requirement that these governing bodies must include two lay members, at least one registered nurse and one secondary care specialist. The failure, however, to prescribe in detail the wider professional membership or the ratio of GPs to other professionals is an error. While there ought to be flexibility to co-opt members according to the requirements of local need, it is important that all clinical commissioning groups have the same core membership. There is a huge difference in having a place at the table by right and being invited to sit there by a pre-existing statutory group. Professionals such as pharmacists, allied health professionals, chaplains and psychologists provide valuable and essential insight into the health needs of populations. This ought to be reflected in the core membership of clinical commissioning groups.

There is much more I could say, but I will adhere to the time limit by concluding that I believe, along with many noble Lords, that some reform of the NHS is necessary to enable it to face the challenges of the future. Aspects of this Bill are to be welcomed, such as the desire to bring greater transparency and patient choice into healthcare, and the desire to involve health professionals more fully in commissioning services. None the less, there are still major problems with the Bill, including those outlined above, that require to be addressed before it can be supported.

12.24 pm

Baroness Bottomley of Nettlestone: My Lords, I am delighted to follow the right reverend Prelate and relate to him the advice first given to me when I was one of the two people who planned to speak in this debate along with another former Secretary of State for Health. I look forward to hearing what my noble friend Lord Fowler says towards the end of it. The advice I was given was first to find the chaplain as he will tell you what is really going on in a hospital or health institution.

I give this Bill an unequivocal and extraordinarily warm welcome. For someone who has spent the best, hardest and most rewarding years of their life as a Health Minister and then a Secretary of State, I enjoy hearing people say, "The Secretary of State should be hands on". I do not think that many of the people who work with me would think I was anything other than hands on, but I have discovered that five years of sleeping four hours a night still does not mean you can cover the full detail of everything that is going on within the National Health Service.

I welcome this clarity of the roles, responsibilities and institutions which I believe will lead to a much more effective and better managed health service. We may spend £128 billion a year on the health service and there may be nearly a million people working in it, but I remind the House that in the past 13 years there have been six Secretaries of State. That means a massive organisation getting ready for one Secretary of State, then another Secretary of State, then another, and any number of junior Ministers, all with their special pet projects, all disrupting and trying to leave their mark on the National Health Service. Some in this House dislike comparisons with the commercial world but I am going to make one. One of our successful businesses in the United Kingdom, which is very consumer-responsive, is Tesco. Tesco has half the number of people and half the budget but remains a huge and complex organisation. The chief executive has been on the board for 19 years and he was the chief executive for 12 of those years. It is romantic poppycock to think that the Secretary of State should be personally involved in all these various issues. Aneurin Bevan said that whenever a bedpan drops, the noise reverberates down Whitehall. The point is, it is not the bedpan that the Secretary of State should be concerned with but the much broader strategy, accountability to this House and greater clarity about commissioning, Monitor, public health and patient involvement. I believe that the Secretary of State and his team have addressed many of the knotty problems and conundrums which, as many have said, have been the prime preoccupations of those leading the health service for many years.

The only area where I fall out with the Secretary of State and his team is in describing this as radical, revolutionary and the greatest change the NHS has ever seen. That is total nonsense. Those of us who have been involved in the very close detail of the health service over the years have all tried to get the balance right. We have tried to get the balance right with local authorities. That is very difficult with regard to continuing care. The budgets of local authorities and of the NHS are entirely different. The accountability is different. Why do we have so many people in prisons? That is not least because there is cost shunting away from social services into the Home Office. I see that the former Chief Inspector of Social Services knows exactly what I mean. Cost pressures arise between social care and the health service. The health and well-being boards and the role of the director of public health are excellent recognition of the areas where local authorities can and should be in a powerful position but should leave the health service to deliver this highly complex challenging work for the 21st century.

Patients are not mild, obedient, good and kind and are not as deferential as they were in the past. There are more hits on the internet on health than on any other subject. Patients are experts. They go to see their doctors and say, "I have looked you up on the internet and these are the research papers I have seen. Why haven't you produced this or that?". It is a totally different relationship—a partnership. It is a good relationship but it is a very different world, particularly if you are a clinician. The development of HealthWatch and the information available for patients has got the balance right.

My noble friend Lord Howe said that this Bill has already had the most unprecedented amount of scrutiny—40 sessions in another place and 100 Peers hoping to discuss it. During this period and during the listening exercise, there have been some very informed and clear improvements. I dare say that we might have achieved them in Committee but the listening exercise has provided many of them. The role of Monitor has been excellently refined. It has allowed the transitional phases to develop, but the health service needs a bit of

[Baroness Bottomley of Nettlestone]
muscular intervention. During my time, a thousand years ago, we had regional chairmen. Sir Donald Wilson in the north-west sorted people out and banged their heads together. He was a farmer. If you were very good you got a cheese and if you were very, very good you got a sack of potatoes, but he knew how to intervene when the different forces—the tribes of the feudal tendency in the NHS—were at a logjam. Last week, Monitor intervened in Manchester regarding the seven provider hospitals to the Christie. We need that mechanism where intervention can occur.

I support the Secretary of State and his team. Too many people in this House are in their anecdotage but I need to pass on two anecdotes. The two people who used comprehensively to beat me up in a close encounter with Jeremy Paxman or John Humphrys were the head of the BMA, Jeremy Lee-Potter, and his successor, Sandy Macara. Jeremy Lee-Potter was based at a hospital in Poole. I was always hearing that the changes would lead to rack and ruin, the end of the health service and that the terrible, wicked, infernal market would be ghastly, so I visited the Poole hospital. I said that I wanted to meet a team of people, young and old, to ask how things were going. Universally, they all said, "These trusts are really good. They are really working". I bumped into Jeremy Lee-Potter in the haematology department and told him what I had heard. He said, "I know, Virginia, it is very good at Poole but everywhere else there is a problem".

My other example concerns Sandy Macara, a public health doctor. I was passionate about public health and am so pleased at what we are doing with public health. Sandy Macara comprehensively beat me up on the "Today" programme and spat me out the window. I had to go home covered in bandages. On my way out of the studio, he said, "I do hope that will help, Virginia". There is an institutional belief that if you make a big noise about the Health Service it will attract more resource, so going quietly is never an option because people have to make a great noise to make sure that they continue to be properly recognised.

I am pleased to speak after the noble Lord, Lord Birt. When he was running the BBC I felt that he was a kindred spirit in that if you mind about the mission, you have to do unpopular things. If you did not care, you could give everybody what they wanted all the time, but if you care you have to tackle the difficult problems. A former BBC chairman, who was also chairman of an NHS trust, used to cite Burke. Goodness knows, our Secretary of State has given dedicated, committed attention to this issue over many years. Edmund Burke said that you must be,

"proof against the most fatiguing delays, the most mortifying disappointments, the most shocking insults; and, what is severer than all, the presumptuous judgment of the ignorant upon their designs".

I have had correspondence—as we all have—from any number of people who are frightened by the Bill. One correspondent says:

"Please ensure my grandchildren can have the same benefits that you and I have received from the NHS since 1948".

I do not want my grandchildren to have the same benefits; my grandchildren have high standards. Like everybody else in this House, I want my grandchildren to have a better, more responsive, more effective and cost-effective NHS. Only through this Bill will we achieve that.

12.34 pm

Lord Darzi of Denham: My Lords, we live in a time of rising fear. We fear losing our jobs, we fear riots in the streets and we fear that our economic future and our country's place in the world are no longer secure. A little over 60 years ago, the National Health Service was founded to take away the fear that getting sick meant going broke, and growing old meant becoming poor, with rising healthcare bills.

Today, people need our NHS more than ever. It remains this country's most cherished institution. One might conclude that, since our NHS is so precious, it should be protected from change. That is untrue. The NHS must embrace change. To believe in the NHS is to believe in its reform. Healthcare exists at the edge of science. We are constantly finding new drugs and treatments, and innovations in what we do and how we deliver care. The history of medicine has been the history of progress. People rightly expect the latest treatments in the most modern settings. In modern healthcare, to stand still is to fall back.

I will address the three most important features of the Bill before the House. The first is the meaning of competition. The second is the relationship between quality and clinical commissioning. The third is the leadership and management of the NHS. First, there has been much unreasoned debate on competition and choice. They are two sides of the same coin, arrived at from very different starting points. One starts with the ideology of faith in free markets and the responsiveness of corporations to competition in the thirst for profit. The other starts with faith in people and in their capacity to make good choices for themselves, supported and empowered by professionals.

When I was a Minister we introduced free choice, public or private, for all patients. Competition was a means, not an end in itself. With prices fixed and patients empowered, professionals could compete to provide the highest quality care for patients. The right competition for the right reasons can drive us to achieve more, work harder, strive higher, and stretch our hands and reach for excellence. It can spark creativity and light the fire of innovation.

I will also tell noble Lords what I know to be true. There has always been choice in the NHS—but for the few, not the many. Those in the know have always known where to go and how to get there. The reforms of recent years have been about extending choice to the many, not introducing choice for the first time. I fear that the debate today has lost its mind. I have been shocked by the ability to take a pragmatic concept and apply it to the point of absurdity.

I will make one final point on competition. I am tired of the victim mindset in the NHS. It is absolutely wrong and we need radical cultural change to change it. Let us be clear: we have an enormous depth of clinical talent; we have world-leading research; and we provide excellent quality care. In the past decade, waiting times have dropped from 18 months to just a few weeks. In 2009, 92 per cent of our patients rated their care as good, very good or excellent.

Secondly, we must not lose sight of our purpose: raising the quality of care for patients is what inspired me throughout my career. It is an ambition that I share with colleagues across the NHS. It is our collective purpose and common endeavour. I summed it up in the title of my review of the NHS, *High Quality Care for All*. Today, the NHS faces the huge challenge of raising the quality and efficiency of its services. Fortunately, in healthcare, quality and efficiency are two sides of the same coin. This twin challenge seems to have been lost in the technocratic debate on commissioning.

If clinical commissioning is about empowering clinicians to reshape and reform services in order to improve the quality of care for patients, it has my wholehearted support. However, I need Ministers to give their reassurance that all clinical professionals—GPs, community services and specialists working together—will undertake commissioning. As a surgeon, I would not know where to begin if I was asked to commission community podiatry services. I expect my GP colleagues would find it equally challenging to commission the highly specialised cancer services that my organisation delivers. In the 21st century, we need more integrated care, not more division. We need a health service that harnesses the talent of all our professionals, with a focus on integration and quality above all else.

Finally, I address the question of leadership and management in the NHS. The question is: how do you get the health service to change? How can reform lead to improvements in patient care? My first point is that we in both Houses must stop our frequent assaults on NHS management. If the newly appointed chief executive of a FTSE 100 company came into office and announced that he was firing half the company's management, shareholders would rightly revolt. Attacking NHS management may be good politics, but it is bad policy—and in the long run it will be self-defeating. Change in the NHS happens when coalitions of patients, clinicians and managers come together to break the status quo and to make the difficult decisions that are required to improve patient care. I say "difficult" because changing services is rarely popular. Given the demonisation of those making the changes, that is not a surprise.

Secondly, nothing in the Bill explains how strategic changes will be made to the NHS. With perhaps 300 consortia, how will the necessary changes be made on a regional level? The programme that I led, Healthcare for London, built an alliance of hundreds of clinicians and managers across the capital to improve care. It led to London becoming the world leader in stroke and cardiac care, and dramatically improved the quality of primary care provision. How will similar improvements happen in future?

We had "too big to fail" in the banking sector. Now, healthcare faces a set of reforms that are striking in their managerial complexity, with many changes begun prior to the Bill. We now have health and well-being boards, clinical commissioning groups, clinical senates, local health watches, the NHS commissioning board, a quality regulator and an economic regulator—the list goes on. Is this now "too complex to quit"? At the end of the day, who is responsible for making sure that the NHS saves more lives this year than last? Who is accountable for how its budget is spent? Who will improve quality at system level, rather than in an individual organisation or consulting room? Who will inspire NHS staff to lead the difficult changes? What is coming next?

I am a surgeon, so perhaps I may be allowed a surgical analogy. It is the area I know best. The patient—the NHS—is on the table. It has been put to sleep and we have spent the past 18 months worrying more about new commissioning structures than about raising quality and productivity. The incision has been made, the old structures have been swept away and the new structures are beginning to form. The team could not agree on what operation to do. We have already had time out, and future forums have made some good suggestions after the Government failed to listen to the concerns of patients and staff from the start. The question is: what next?

Is more waiting around what the NHS needs? The answer is no. We need to know where we are going and how and when we will get there. This has been a bumpy journey and it would be cruel to refuse to put the end in sight. That is why I find it difficult at this stage to support the amendment of my noble friend Lord Rea. I stand before noble Lords not as a politician but as a surgeon working in the NHS, with the needs of my patients and colleagues at the front of my mind. Our NHS needs leadership. We must never lose sight of our purpose. We aspire to high-quality care for all. The obligation of the Members of this and the other House is to support the NHS to do the things that are tough because they are right.

12.44 pm

Lord Clement-Jones: My Lords, it is a privilege to follow that superb speech by the noble Lord, Lord Darzi, and I agree with almost every word he said.

First, I declare an interest as a member of the College of Medicine advisory board and as chair of the council of the School of Pharmacy. What the noble Lord, Lord Darzi, has said reinforces my view that this is a classic "I would not have started from here" situation. After all the major structural changes under the last Government, I am more than ever convinced that constant structural change is damaging to the NHS. I believe that reforms designed to achieve changes of culture more than complex changes in structure are far more effective in the long run at meeting challenges.

With much improved treatments and longer life spans, coping with long-term conditions in health and social care is now the greatest challenge for the NHS. As a result, we need a health system that is capable of meeting huge challenges such as diabetes and obesity. As the Future Forum says, we need a reassessment of the "old model" of hospital care, where domiciliary and community care are available and adequately resourced. Patients must be able to take more responsibility for their own health. They must have more power and choice in the system, both as citizens and consumers. There must be much better integration of health and social care.

The current NHS is by no means perfectly adapted to tackling these future health needs. This is compounded by a financial context in which we need

[Lord Clement-Jones]
to meet the Nicholson challenge of productivity savings of £20 billion over the next five years in order to be able to meet future patient needs. However, this has been poorly communicated. We need transparency about how and why money is being saved in the NHS. At present, to many in the health service, it looks as though cuts are being made rather than resources being redeployed.

However, let me be clear: I welcome many of the elements in the Bill, particularly the improvements conceded after the Future Forum report. I congratulate Professor Field and his colleagues on their work. I welcome the recognition that the paramount duty of Monitor as health regulator must be,

"to protect and promote the interests of people who use health care services",

and that where appropriate Monitor must exercise its functions in an integrated way to achieve this both within the NHS and between health and social care.

On these Benches we have long supported devolving power to local communities. I welcome the fact that through health and well-being boards, health and social care will be brought together in local communities and local authorities will take on new responsibilities for securing and improving public health. I also welcome a less aggressive timetable for the reforms and commissioning closer to the clinicians.

Therefore, I believe that the Bill is heading in broadly the right direction but there are several elements that I hope to see examined very carefully during its passage. Are the new structures too cumbersome and complex? Will the CCGs and clusters have sufficient weight and expertise when commissioning from foundation trusts? How will CCGs work together in commissioning for less common conditions?

In particular, I want to probe the role that community pharmacists can play in these new NHS structures. There is absolutely no doubt about the contribution that community pharmacies can make. However, there is much untapped potential and many underused facilities, despite pharmacies gearing up to deliver enhanced services such as screening, health checks and medicines management. What will their place be within the new health and well-being boards? What representation of and consultation with community pharmacy will there be throughout the new commissioning system, at NCB and CCG level? Should there be a duty on these commissioning groups to consult widely as there is currently with PCTs? My noble friend the Minister recently told the Royal Pharmaceutical Society that pharmacists will be "at the heart of the new commissioning arrangements"—in what way?

There is the future place of the health networks, in particular their funding for cancer, cardiac and diabetes. Do they have a long-term future? Then there is the fraught area of competition. Generally I support the ambition of commissioning any qualified provider in appropriate areas subject to a system of local and national tariffs. Under the previous Government, procurement by PCTs from the private and voluntary sector was encouraged in a number of areas such as podiatry, psychological therapies and wheelchair services. The right sort of competition between providers can drive improvements in quality and efficiency and hence patient care and choice. However, this is definitely not the case in all services and the challenge is ensuring that this can happen in selected areas without opening up the NHS to legal action in a way that lets European competition law rip and dismantles the fundamentals of the health service as we know it.

European competition law could bite in unexpected ways. The application of competition law to the NHS under existing law has been a grey area for some years. It is not a new issue but we should not do anything to exacerbate it. It is crucial that for the purposes of EU law applied by the Competition Act and the Enterprise Act, publicly funded trusts are not regarded as "undertakings", otherwise the full rigour of competition law will apply. The limited European case law seems to indicate that it will not if services are provided on a universal basis on the principle of solidarity.

Therefore, I welcome some of the changes that have already been made to Monitor's duties, mentioned earlier. However, there are other aspects that I and others believe, and are advised, are less positive and will lead to the risks that I have described: the lifting of the cap on foundation trusts' private patient income, which could set foundation trusts directly in unfettered commercial competition with the private sector and risk claims of cross-subsidisation; and the termination of foundation trust regulation in 2016. I also have my doubts about whether putting the *Principles and Rules of Co-operation and Competition* on a statutory footing will be a step in the right direction since this could amount to an admission that the full rigour of competition law is to apply. We need to examine all these matters in depth as the Bill progresses.

Finally, of course, we have the issue that has attracted the greatest attention in recent weeks. The Constitution Committee asked whether the change in the Secretary of State's duties and powers under the Bill threatens the operation of a comprehensive health service. I do not believe in substance that it does but we will want to consider this extremely carefully during the passage of the Bill and in particular the autonomy provisions.

The House has yet to hear from the noble Lord, Lord Owen, but I am convinced that we absolutely do not need a Select Committee to examine this matter. A Committee of this House sitting in this Chamber is perfectly competent and capable of examining this issue with great care. On that basis, tomorrow I shall be firmly voting against the proposition put forward the noble Lord, Lord Owen.

12.52 pm

Lord Owen: My Lords, I speak, obviously, in favour of the Motion in my name but also to explain how it has come about. My noble friend Lord Hennessy and I have been involved with the Government, and particularly the noble Earl, Lord Howe, for over two hours of very serious negotiations on two occasions. He treated us at all times with great consideration, as we would expect, and we explored the concept of a different form of Select Committee than had been earlier envisaged. We changed our position and I think it would not be unfair to say that he changed his position. As he said, we came very close to agreement.

The only reason we have not been able to come to an agreement is, as he said, that we were not able, Lord Hennessy and I,

"to agree to a strict timetable on how to proceed".

Now let me explain. We are individual Cross-Benchers and so do not take part in discussions on the allocation of time. We were ready to go with the Leader of the House as far as we could, in that we said that if this went to a Select Committee and we changed the Select Committee's remit just to relate to the issues raised by this all-party report of the Constitution Committee, we were ready to take account of all these things. But the one thing we could not do is form a judgment on how much time this House should spend on the whole of this Bill. We went one step further. We said that, since they were thinking in terms of two days on the Floor of the House early in January, after the report of the Select Committee came back to the House on 19 December, then that would be a fair allocation of time. But we could not go that step further. We came back and talked to the Convenor of the Cross-Bench Peers and he went immediately to speak to the Leader of the House, the noble Lord, Lord Strathclyde, to say that this was not the role of Cross-Benchers and that he would not be happy for Cross-Benchers to get involved in this area. So that is the reason.

But let me explain to the House, the Select Committee and, particularly, to the last speaker. I would like to go to the essence of the Health Service. I got into trouble when I was Minister of Health for using the words "a rationed health service". I have repeated that on many, many occasions. Health spending is almost unlimited. We ration the health service and yet it remains enormously popular with the public. It is the one institution which no political party up until now has really threatened. Why is this? There are many reasons, but I do believe that a deep reason is that the public think that the rationing process is fair: that it is rooted in democracy, it is rooted in Parliament.

The purists have got at this Bill. I am a reformer. I was the first person to advocate an internal market in the National Health Service, but I never believed that it would lead to an external market—a pure market. Health is not a public utility. Health is different. Sometimes the health professions have talked too much about money to Ministers of Health, as Enoch Powell said, in a classic speech. We must cherish the fact that it is a pool of altruism in our society. It is different. People commit hours of time—surgeons and porters, nurses and physiotherapists—far beyond the call of duty, ignoring the EU directives, time after time. Are we going to foster that; are we going to keep it?

The other purist issue of this Bill is first to go for an external market and secondly to think that you can separate out the running of the health service entirely, in its production, from the Secretary of State. The Secretary of State's role has never been, for many years, to manage the health service, in the strictest sense. This Bill has, in my view, some good provisions relating to decentralisation of the health service and it is, of course, right that there should be some re-adjustment of the management role of the Secretary of State, making it a bit more explicit about that which is going to be delegated. But you must preserve a role for the Secretary of State.

I am very worried that this Bill does not deal with what would happen in a pandemic. In a pandemic that suddenly grips this country we will not be able to accept that the Health Service is managed by the Chairman of the National Health Service Commissioning Board. We will instinctively come back to the Houses of Parliament. When inflation was running at nearly 28 per cent in the early 1970s, we had to adjust area health budgets not just on a monthly basis but on a weekly one. That dialogue with the Treasury had to take place between Ministers. Barbara Castle was a Minister who was formidable in extracting money almost day after day to deal with the inflationary situation. The Secretary of State cannot stand aside from all these things. I see a former Chancellor of the Exchequer, the noble Lord, Lord Lawson. He knows too that in a rationing process it is not just what you spend by the state, it is also what you spend privately. It is the total budget that health takes. And if it gets too high, as it has undoubtedly done in the United States, it takes away from other private or public sectors. So this rationing process is one in which we are all involved. A Select Committee is the only procedure that can look at the complexity of this new relationship that we are trying to establish. If we get it wrong, we will be in very serious trouble.

The whole process of how we deal with failures must be dealt with. We admit there are going to be failures in some Trust hospitals. There are going to be failures in some commissioning groups. If there was widespread failure, I think the public would find it very difficult that the issue was only being dealt with by the chairman of a quango — the largest quango we have ever created in this country.

I therefore beg the House to seriously consider this Motion. It is not a blocking measure, as my noble friend and I have made it absolutely clear. We accept that this is a reforming Chamber. Outside, at this moment, they are assembling a petition to support the idea of a Select Committee looking at the role of the Secretary of State. It is gathering momentum as I speak and I hope the House will listen to that before they go and reject this Motion. I am surprised by the tone of the Government's reply to the Select Committee, which I got just this morning before we started. I stress this is an all-party, unanimous Select Committee. I leave it to the Chairman of that Committee, who is speaking after me, to deal with these issues.

Cherish the fact that the NHS is one of the most popular public institutions in our country. Look hard at how we can retain that. Do not believe that, in adversarial debates across the floor of this House, you can get the balance right—the new balance that is needed for the Secretary of State for Health.

1 pm

Baroness Jay of Paddington: My Lords, I am delighted to follow the noble Lord, Lord Owen, and I will pursue the points he raised about findings of the Select Committee on the Constitution on the role of the Secretary of State. However, I start by also following the noble Lord in speaking briefly about what I see as the underlying principles of the NHS and the public understanding of them.

[Baroness Jay of Paddington]

Almost exactly 15 years ago, in November 1996, I was proud to introduce a debate in your Lordships' House to mark the 50th anniversary of the founding of the NHS, which also sought to reassert its public values. As so often happens in general debates in your Lordships' House, the debate attracted a wide range of speakers, some of whom I am delighted to see are also speaking today. There was general agreement on that occasion that, although healthcare and people's expectations of it, as the noble Lord, Lord Darzi, reminded us, have changed vastly since the 1940s, the old values of social solidarity and collective responsibility must be maintained into the 21st century. On that day for me and, I think, for many others present, the argument was given special force and passion by the late Lord Bruce of Donington, Donald Bruce, who was Aneurin Bevan's Parliamentary Secretary and helped to steer the original founding Bill through Parliament.

As today we are beginning our scrutiny of a Bill promoted as the biggest shake-up of the NHS since it began, I do not think it is irrelevant to look back at the principles which Donald Bruce and his parliamentary colleagues created. Recently I found again my family's somewhat dog-eared copy of Aneurin Bevan's testament, *In Place of Fear*. I am glad to echo the words of the noble Lord, Lord Darzi—in place of fear. The first sentence in the chapter on a free health service reads:

"The field in which the claims of individual commercialism come into most immediate conflict with reputable notions of social values is that of health".

I say "hear, hear!" to that in 2011, as I would have done in 1946. He goes on later to say:

"A free NHS is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst".

I want to repeat those words not because I have any desire at all to see the NHS preserved in a kind of post-war aspic. Like other noble Lords who have spoken from these Benches, and indeed around the House, I am entirely in favour of change. But it is legitimate, when today's Government assert that they are proposing fundamental change while at the same time maintaining those underlying values, to test their proposals against some simple and original principles.

Let me say at the outset that I have never been a Bevanite or an Old Labour purist about the provision of health services. I have long believed in a mixed economy of providers, and noble Lords around the House have correctly drawn attention to the changes made by the Labour Government in that direction. I could say anecdotally, to coin the phrase of the noble Baroness, Lady Bottomley—I hope that I am not being anecdotal in a negative sense, but in order to be illustrative—that right at the beginning of Tony Blair's Government, my right honourable friend Alan Milburn and I, as Ministers of State in the Department of Health, argued—I have to say unsuccessfully—that a private sector company should be allowed to build and equip a renal dialysis centre in a part of the country where the existing services were inadequate. Had that service happened—as I say, it did not—the centre would, of course, have been staffed and managed by the health service. When Alan Milburn later became Secretary of State, he did indeed allow some aspects of private sector involvement, as well as the voluntary and charitable sectors, to intervene in order to extend and improve local patient care. I am delighted that my noble friend Lord Hutton of Furness is to speak later in the debate because I am sure that he will record from his own history the way that programme was taken forward by the previous Government. However, I supported it only if—this was the central underlying condition—those providers were appropriately managed and planned for in the interests of patients and not the providers, based exclusively on quality and not on price competition, and remained firmly within the framework of NHS accountability.

Today, I have to say there is already an expectation, perhaps in anticipation of this Bill's passage, that a free market is opening up in a completely different way. I was alarmed to learn only 10 days ago, for example, that in Surrey a private company owned by the Virgin corporation is now the preferred bidder to run community health services in a deal worth about £500 million. The particularly disturbing aspect of the Surrey decision is that Assura Medical, the Virgin company, is preferred over a well respected local social enterprise mutual organisation, appearing to confirm fears that large multinational businesses will win out over smaller, less commercially sophisticated providers. I must say to the noble Baroness, Lady Bottomley, that I was not encouraged by her invoking the Tesco example.

If this is the future the Bill will create, it is a revolutionary and unwelcome system. This is a completely free, competitive market—a long way from the mixed economy of publicly accountable provision within the NHS set-up which I can accept as consistent with the original principles of the service. However, with the leave of the House I shall take a few minutes to come back to the principles of accountability, particularly the democratic accountability of the NHS. I want to refer to the recently published report of your Lordships' Committee on the Constitution, which I am privileged to chair, and to which the noble Lord, Lord Owen, and other speakers have already referred. As the Minister has said, we have already had a response to the report, but I am afraid to say that I only received it this morning and therefore he and the House will understand that the Committee has had no chance to consider it in detail. However, I echo the concern of the noble Lord, Lord Owen, that although the Minister has been encouraging in private conversation and in his speech today about the possibility of amending the Bill so as to counter the concerns of the Committee about accountability, the wording of his letter written to me last night states:

"We do not consider any amendments necessary to put this matter beyond legal doubt",

which is an exact contradiction of what the Committee has said and what I understood the noble Earl to say in his opening remarks. Perhaps that can be clarified.

The primary concern of the committee is the question of the duties of the Secretary of State and his legal responsibility. To emphasise the point picked up by the noble Lord, Lord Clement-Jones, it is not that the Secretary of State and the Department of Health currently provide health services which under the Bill would be provided instead by clinical commissioning groups—everyone understands that Ministers have never

directly provided services—but that under existing legislation, the Secretary of State is constitutionally and legally responsible for the provision of healthcare, whoever provides it and wherever it is provided. There are new so-called safeguards in the Bill in Clauses 49 and 50, but the Constitution Committee regards them as only a modest contribution towards a new form of accountability, and your Lordships may not regard them as sufficient.

Of course, the Constitution Committee has already proposed a simple solution; that is, to retain the existing wording in the current Act which in our view reflects the founding provisions established in 1946. I was surprised that in many exchanges in the House of Commons, Ministers seemed to be dismissive of concerns about these constitutional matters, simply suggesting that their words and the Department of Health statements were sufficient to guarantee that established health service principles were, to use the cliché, safe in their hands. Frankly, that arouses my suspicions. If the Government feel it is so obvious that the words in the Bill are irrelevant to the long-standing commitment of the Secretary of State to his responsibilities, there really is no reason why they should not accept the existing words as they are set out in the existing Bill. Perhaps I may find the quotation from the Minister's letter which suggests that he would be unable to deal with that fact. I ask the forgiveness of noble Lords. I received the letter only this morning and I may have lost the relevant page. However, I am sure we will return to this in Committee or at a later stage, but I was not encouraged by the Government's response to the Committee's report. As the noble Lord, Lord Owen, said, it was a thorough cross-party recommendation. If my suspicion that the Government are perfectly content to dilute their legal and constitutional responsibilities is correct, that is in order—as it states in another important clause, Clause 4—to promote "autonomy"; in other words, to promote a completely free, competitive market.

I apologise for the length of my contribution, but in conclusion I have been surprised by the volume of public correspondence precisely on the points raised in the Constitution Committee's report. There is clearly a widespread fear that this Bill will erode the democratic accountability of the NHS as well as the ethical co-operative foundations of the service. In my view, the Bill will need to be properly amended to allay those fears, and I would be grateful if the Minister will make it clear in his concluding remarks whether the Government are still open to that, and to be true to the founding principles. As a first step, I will certainly support the Motion put forward by the noble Lord, Lord Owen, that a special Select Committee should be established.

1.12 pm

Lord Kakkar: My Lords, I thank the Minister for his thoughtful introduction of this Bill and in so doing declare my own interest as professor of surgery at University College London and as consultant surgeon to University College London Hospitals NHS Foundation Trust. It is as a practising surgeon that I recognise the need for Governments to attend to the question of the National Health Service through the introduction of Bills that ensure its long-term sustainability.

I also welcome the personal commitment to the National Health Service of the Prime Minister, the Deputy Prime Minister and the Secretary of State for Health. Those commitments, however, and indeed the introduction of this Bill, are themselves not sufficient: as we have heard from the noble Earl, Lord Howe, any Bill addressing the future of healthcare in our country must address the serious challenges that all healthcare systems around the world face.

These challenges represent the demographic change in society, with an ageing population attended by more chronic disease requiring ever greater intervention; the need to improve clinical outcomes to ensure that our patients receive the best healthcare possible and that this is done with due attention to the introduction of innovation, technology and new methods of treatment to achieve those improved outcomes; and, finally, that the provision of healthcare is delivered in the most cost-effective fashion to ensure that the vital funds available for healthcare are used most appropriately, recognising that the our economy faces a very serious challenge and will do so for many years to come and that the funds available for all public services, including healthcare, will therefore be limited.

How are we to chart these dangerous and difficult waters? I believe that our north star should be the patient and our road map the National Health Service Act 1946. That Act has defined the way that healthcare has been delivered in our country for six decades—and rightly so. But the legacy of Bevan's settlement has some important problems today with regard to the delivery of healthcare, specifically with regard to a particularly centralised approach to decision-making and the failure to engage at the outset primary care practitioners.

This Bill has the opportunity to deal with those two important issues in such a way that the foundations of the NHS, laid in 1946, can be built upon. If those two issues are addressed successfully, then local talent and innovation, driving the development of new therapies and new ways of delivering care, will help improve clinical outcomes. Full engagement of our colleagues in primary care, in the management of the service and its resources, will better help us connect with patients, the focus of our service.

There remains considerable anxiety about this Bill, not only among healthcare professionals, but among the people of our country more generally. As we have heard, this Bill comes for consideration at a time when our nation faces considerable challenges and difficulties. The national state of mind is one of anxiety, but there is also professional anxiety because of the scope and potential complexity of this Bill, which may be attended by unintended consequences that could disrupt the provision of universal healthcare. The profession is also concerned because previous reorganisations and upheavals, although well meaning, have not always delivered the benefits that were intended, and sometimes have had detrimental consequences.

It is the responsibility of your Lordships' House to move forward with careful consideration of all matters in this complex Bill to allay those anxieties, having undertaken very effective scrutiny and, where necessary, appropriate amendment of the Bill.

[LORD KAKKAR]

I have a number of specific concerns beyond the accountability of the Secretary of State and how competition on the basis of quality will be promoted. I am concerned about how the new clinical commissioning groups are going to discharge their responsibilities in accordance with the Nolan principles of standards in public life. These are new public bodies and they will potentially be in a conflicted situation in their localities. These standards in public life need to be strongly promoted and maintained.

I am concerned also about how we are going to focus on outcomes in primary care and ensure that the delivery of primary care meets the very highest standards within the structures that are proposed. As a surgical academic, I am concerned about the potential impact on teaching, training and research, although I believe that there are opportunities for the Bill to address those issues and ensure that the vibrant academic basis for medicine in our country is strongly promoted.

Finally, I am concerned about how we will deal with failures of entire organisations and failure of services within those organisations before they reach a point where the welfare of patients is put into jeopardy.

Beyond legislation, Her Majesty's Government need also to outline their strategy for implementation. It is fine that we have a Bill, but the two fundamental issues that need to be addressed will be the question of culture change in the NHS and the development of leadership to ensure that the changes necessary to protect and promote the interests of our patients are properly delivered.

Beyond culture change and leadership, I am also concerned that this Bill is subjected early to appropriate host legislative scrutiny. It is an important Bill with important consequences and I hope that a mechanism will be found to establish a committee that would follow this Bill, through its implementation, to determine that what was anticipated is actually achieved.

Healthcare has always been a highly charged and somewhat political issue. The birth of the National Health Service in 1946 was a highly political issue and every reorganisation since has been attended by controversy. Your Lordships' House, however, has never felt it necessary to deny a health Bill a Second Reading, although in the health Bill in 2003, there was a vote at Second Reading. Nor has your Lordships' House felt it necessary to send parts of a Health Bill to a Select Committee. It has always felt itself able, with its vast expertise ranging from previous Secretaries of State for Health, constitutional lawyers, current and former medical and other healthcare practitioners, regulators and those more broadly involved in public life to provide the necessary scrutiny for a health Bill. Indeed, I believe that the people of our country expect us to provide thorough, vigorous but thoughtful scrutiny of this Bill to ensure continued universal healthcare, free at the point of delivery, for all the people of our country.

1.21 pm

Lord Naseby: My Lords, all my political life of some 40 years plus, I have been involved in debating the National Health Service. Reflecting on that time, this Bill is probably the most important debate on it over those years. I want to make it clear that I support the Bill. More importantly, I support the need for the Bill. The need is clear because we do not today have an NHS that is the envy of the world, which is something to which all of us in this Chamber would aspire.

Numerous problems need to be tackled, many of which were not tackled by the previous Government. Unless they are tackled in the near future, the outcomes for NHS patients will deteriorate. I compliment the previous Government on what they did as regards funding; namely, to increase the NHS budget, bringing it up as a percentage of GDP that is fairly comparable to France and Germany. But, sadly, whatever the noble Lord, Lord Rea, may think, read or say, we do not have a health service comparable to either of those countries.

However, the crying shame and legacy of that increased expenditure is that it was not achieved with productivity at the same time. The result is that the service is not able today to handle the demand, nor is it able to properly control its budgets and expenditure. We know therefore that, as a result, there is the problem of £20 million of efficiency savings left by the previous Government for the coalition to deal with.

The first challenge is how to get a real grip on expenditure to ensure that money is spent on patient care and not on bureaucracy. That is at the heart of the strategy of why my ministerial friends have produced this Bill. I personally welcome the end of PCTs, the removal of the other layers of bureaucracy and their replacement by GP commissioning. After all, we previously had GP fundholding, which worked really well for those who took part, particularly for patients as waiting times were driven down and minor surgery blossomed. But the problem was that it was not compulsory.

I recognise that this is a Second Reading debate. Therefore, we need to look at all the many representations that I and others of your Lordships' House have had in Committee, but not today. But I want to highlight some of the key issues that are sitting there writ large. Nursing standards in the NHS have fallen. The evidence is there for all to see. Somehow, the NHS and the Royal College of Nursing have to get a grip on this issue and have a total review of the training, the responsibilities, the supply for general nursing and for specialists, and, above all, the attitude of nursing patients.

On the speaking of English, for too long the NHS has gone out and recruited doctors and nurses in huge numbers overseas and, allegedly, someone has checked their English. But we all know that that has not happened properly. There now needs to be a rigorous system of the checking of qualifications and the ability to speak English, particularly the ability to understand English in a medical context.

Perhaps more controversially, we need to have a long look at medical students. There is a clear need to review the number in training of doctors, nurses, physios et cetera. I have to say that, for one reason or another, today's medical school intake—the majority of whom are now women—is not working. I do not know why women do not stay in medicine but the majority of them do not. Medical schools need to

look at this. The net result is that we have too few senior doctors because the female medical students have not stayed for too long in the service.

Why do we still have mixed wards in this country? We must be the only leading country in the world that still has mixed wards. I say to my noble friend on the Front Bench that I hope he will have a mission—for as long as he is on the Front Bench—to get rid of all mixed wards.

I have spoken previously on medicine, which I know something about in detail. GPs are one of the key gatekeepers and they are assisted by modern medicines, thus reducing the problems for hospital care. It is interesting that the money spent on medicines as a percentage of total healthcare spending has not changed very much over the decades. The NHS has to resist buying always at the cheapest level. It also needs to stop making its own medicines, as it does in certain hospitals. I am very sorry to say that an increasing problem is one of false and counterfeit medicines, to which somehow we need to find an answer.

There needs to be a better understanding of the appropriate relationship between the pharmaceutical industry and the NHS. There needs to be an understanding that incremental improvements in drugs are to be valued and not rejected. If we are not careful and do not get that relationship right, we shall end up with more problems similar to Pfizer's withdrawal from Sandwich.

Frankly, I think that there is something wrong with NICE. Why does it take longer than any other comparable body? Why does it refuse medicines that are accepted in Europe and even accepted in Scotland? I will not comment on community care, other than to say that it is a key issue in the Bill, which we all know needs to be looked at in huge depth.

Finally, competition is good for any industry. It makes it possible for new innovations, for better value for money and for solutions to be found. Competition gives people pride and responsibility. Even within the NHS there are numerous examples. To highlight eye care, what a transformation there has been from 20 or 30 years ago. The state does not have to undertake everything. It has to be a demanding purchaser, an experienced demanding purchaser, and vigorously assess outcomes.

I welcome this Bill and the Government's attempt to carry out change in a single, coherent programme, rather than a series of piecemeal initiatives, which is what we have had recently. The idea of having a Select Committee is totally inappropriate. I hope that the noble Lord, Lord Owen, will recognise what the noble Lord, Lord Darzi, said. We need to move forward. The NHS needs to know where it is going. Yes, the issue is important but it does not need a separate Select Committee to find an answer.

Lord Owen: The noble Lord must accept that this will not delay the Bill in any stages. The recommendations will be made by 19 December and the House will be considering this Bill into January at the very least.

Lord Naseby: I am sure that the House will be debating the Bill but the noble Lord cannot guarantee exactly when he will come back. He has already said that he could not. I am very sorry, but that would be a further delay, which would stir things up and provide some means of making it more difficult for the Bill to go through. This Bill needs to make progress to improve patient care and it does not need to be thwarted by delay. It is a unique opportunity, which we should grab with both hands, to give the NHS some real leadership. Above all, we should remember that the patient has to come first.

1.30 pm

Baroness Bakewell: My Lords, it is the genius of this country that in recent history it has enacted concepts of major significance in human progress. The Reform Act 1832 transformed our democratic process. The Education Act 1870 inaugurated an era of universal state education. In 1929 the creation of the BBC set the global template for world public service broadcasting. In 1946 the National Health Service was just such a bold and significant leap forward. As we consider how it might be improved, we need to bear in mind what we are changing: one of the finest, most highly regarded and valued institutions of British life, with a global reputation. The enduring essence of the NHS must not be yielded up to the transient imperatives of an external free market.

We must examine this Bill in the light of this conviction. We in the Lords enjoy the privileged opportunity of safeguarding what is so widely cherished. We must be vigilant to deliver improvement without sacrificing the underlying principle, that the NHS belongs to the people and is there to serve their interests.

We must also bear in mind that this Bill is not needed. There is no call for it throughout the country. Levels of satisfaction with the NHS were high and improving. Commissioning improvements were already under way under the last Government. No such proposals as now face us were spelled out in any party manifesto, nor in the coalition agreement. This Bill is in breach of a basic democratic contract.

What is more, many elements of the Bill are already being implemented before the Bill has been enacted. On 19 July Andrew Lansley let slip—it was a good day to bury bad news—that from next April £1 billion worth of NHS services, including wheelchair provision for children and a range of talking therapies, will be opened up to competitive bids from the private sector. The reputable *Daily Telegraph* blogger, Max Pemberton, who is also a doctor, called it,

"the day they signed the death warrant of the NHS".

Such changes are already in progress. This, when the Bill is not yet enacted, is surely constitutionally dubious.

The National Health Service is the victim of its own success. It has kept people healthier for longer and, together with science and public hygiene, delivered a population living years longer than in 1948. Meeting the needs of an ageing population is the biggest challenge that lies ahead. The old are not well served by current provision, or by the proposed changes.

We have before us already a comparison between the NHS and private provision in this country: healthcare for the old is provided by the NHS; social care, the

[Baroness Bakewell]
care of the frail and failing, provided in their homes or in care homes, is subject to the market. For social care, either the state pays for the private provider or individuals and families do. We have already seen two things happen when private finance buys too far into care. First, the service itself can be deficient and the monitoring is poor. Local authorities putting out tenders for care services too often chose the cheapest on offer, risking low standards provided by a shifting population of carers on the minimum wage and with inadequate training. There is already evidence of this happening. Secondly, the care of the elderly becomes a market commodity. The company that first invests moves on and others move in to asset-strip the enterprise for their own gain; then they too move on.

The story of Southern Cross shocked us all. The 33,000 old people in the care of the former company that ran some 750 care homes have been passed from hand to hand. The homes themselves were owned by the Qatar Investment Authority, which charged exorbitant rents to Southern Cross and salted away its profits in the Isle of Man and the Cayman Islands. Southern Cross could not sustain its business model. A Unison report in June 2011 assessed that the care industry was worth £4 billion to private equity investors, but it is considered by them a high-risk investment, with many investors inclined to resell at the highest price in the shortest time. That is what Blackstone Equity had done with Southern Cross. The care of the frail and the needy is far from their first priority. The old are seen as a resource to be milked for profit

The old are not well served by this Bill and yet they are overwhelmingly the most frequent users of NHS services. Patients over 65 account for 60 per cent of admissions and 70 per cent of day beds in NHS hospitals. Following the recommendations of the Dilnot inquiry into how to pay for social care, the NHS Commissioning Board should now call for a fundamental review of how the NHS assesses, prioritises and commissions health services to meet the needs of an ageing population, and what place competing private providers will have.

Private providers have long had a place in the NHS and are important to it and its commissioning process, but let us not go down the American route. A Harvard-led study found that 62 per cent of all bankruptcies in the United States in 2007 were due to medical bills, an increase of 50 per cent in six years. Most of those affected were well-educated middle-class home owners. Astonishingly, three-quarters of them had had their finances destroyed by medical costs even though they had insurance. The latest figures from the World Health Organisation suggest that the US spends 2.4 times more on health per person than in Britain, yet British men live on average two years longer and British women one year longer than in the States.

The NHS has been doing much that is right for 60 years. Every institution can be improved, monopolies can get complacent, and people want choice. However, that does not mean switching the fundamental principle on which this great institution was built. It belongs to the people of this country and they do not want it run on a competitive model.

1.38 pm

Lord Rix: My Lords, before I make my contribution to the debate, it is appropriate that I declare an interest as president of the Royal Mencap Society. In recent years, the NHS has made much progress in how it treats people with a learning disability. However, there remains plenty of scope for further improvement in its performance. It is important to emphasise that my concerns about the content of the Bill should not be interpreted as implying that I have full satisfaction with the status quo: far from it. However, I fear that positive steps that have been made could be undermined as a consequence of the Bill.

As many noble Lords will be aware, Mencap's interest in campaigning on improving the health chances of people with a learning disability is long-standing—with much reason. Research consistently shows that people with a learning disability still experience worse health outcomes and greater inequalities than the rest of the population. They have a shorter life expectancy and an increased risk of an early death. Their overall level of health is also generally poorer. Yet they find it harder to access the health services that for them are so much more of a necessity.

For example, annual health checks for people with a learning disability are vital. They are carried out by GPs, funded by the Department of Health, and are a recognition that people with a learning disability have additional problems with their general health. Yet latest figures show that in England only one in two such people takes up their right to these annual checks, meaning that more needs to be done to ensure that they access the health services to which they are entitled. This is an area where I am concerned that much of the progress over recent years could be undermined if, during a period of major reorganisation in the NHS, we lose focus on making this a priority.

General practice and the promotion of annual health checks are not the only areas of the NHS where progress has been made, but more needs to be done. Mencap's groundbreaking report, *Death by Indifference*, published in 2007, highlighted six premature and totally avoidable deaths of people with a learning disability in the care of the NHS. Your Lordships will recall that, as a consequence of the report, the previous Labour Government established an independent inquiry led by Sir Jonathan Michael, which published a report entitled *Healthcare for All*. This set out the steps that should be taken to prevent similar avoidable deaths in future.

In 2010, Mencap launched its Getting it Right campaign, which encouraged NHS institutions to sign up to a charter setting out reasonable adjustments that they should make to provide equality of health outcomes for people with a learning disability. The charter included steps such as producing materials in accessible formats, employing learning disability liaison nurses, and improving awareness of learning disability among healthcare staff. These steps, and others, have led to many changes in the way people with a learning disability are treated in the NHS. However, while some progress has been made, too often provision remains geographically dispersed and inconsistent. As the Department of Health's *Six Lives: Progress Report*, published in 2010,

revealed, there continue to be concerns around the poor use of mental capacity legislation and the lack of reasonable adjustments to health services.

This is why I believe the real challenge during a period of change and reform in the NHS is to make sure that where progress has been made in driving up better health outcomes for people with a learning disability, that progress is not lost. This is particularly the case for those with more specialist needs, such as people with profound and multiple learning disabilities—PMLD. There is a great deal of concern about the commissioning of health services used by people with PMLD. The specialist services are often extremely expensive and will not offer the economies of scale that other, more profitable or locally attractive health needs can secure. As the number of people with PMLD is relatively small, what incentives will local clinical commissioning groups have to commission such services? Will other, more popular requests prove to be more appealing? What role will the NHS Commissioning Board play in ensuring that the needs of people with PMLD are not ignored?

As noble Lords will be aware, a key element of the Bill, and a fundamental principle of the Government's intentions, is the extension and promotion of patient choice in the NHS. However, "choice" can mean different things and has different connotations for different people, with widely different outcomes. Will those with the most persuasive elbows and articulate voices have greater opportunities for choice than those without? How will people with PMLD exercise choice under the new structures? What support for locally run advocacy services will be provided? What safeguards do the Government intend to put in place to ensure that some of the most vulnerable people in society, such as those with PMLD, can have their voices properly heard?

As I have made clear in my speech, too many people with a learning disability continue to face prejudice and discrimination when trying to access equal healthcare, yet their needs are much greater. I therefore ask the Minister how the Bill aims to tackle the health inequalities to which I have just referred.

Mention was made by my noble friend Lord Owen, who regrettably is not in his place, of Enoch Powell when he was Minister of Health. In 1962 I had occasion to visit him to ask him for an increase in NHS services for people with a learning disability. He told me that it was totally unnecessary and that progress had been made. Of course, he was talking arrant nonsense then, and I would hate to see this Bill reverse the progress that has been made on the implementation of high-quality services for people with a learning disability.

With so many speakers clamouring to have their heartfelt concerns about the Bill heard today and tomorrow, I cannot believe that the Minister will be able to satisfy all our demands in his summing up. Therefore, could he possibly afford the time for a further meeting with those of us who are interested in the world of learning disability?

1.46 pm

Baroness Billingham: My Lords, the overwhelming response to this Bill is: why? Given all the promises made by David Cameron prior to the general election, why is he now supporting such a dire, top-down reorganisation? Why is he reneging on his pledge to support the NHS fully? Why does he turn his face against the most comprehensive criticism from all major organisations and participants in the field of health, or against the opinion of the OECD and the Commonwealth Fund that the NHS is recognised as one of the most efficient and least costly in the world? It can make no sense unless there is an underlying sinister motive to advance the market philosophy into the NHS, which will ultimately destroy it. The cherished principles of the NHS as a universal service will indeed be lost forever.

Today I speak as one of many in this House who are raising fundamental objections to the Bill. The speakers' list is full of the most knowledgeable Members on NHS matters, Members who have given a lifetime of service to the NHS and to the community. I leave to them the forensic analysis and demolition of this Bill. I have no competence compared to them, but I can and will speak on behalf of those who have no voice here and who have written to me in their dozens, and on behalf of those who will rely on the NHS for their health provision in the future.

I also speak as one who very recently saw first hand the outstanding excellence of the NHS in all its separate parts and stages. The tumour on my lung was diagnosed by clinical excellence and co-operation, from my GP in West Hampstead to my local hospital, the Royal Free, and finally to my surgeon at the Royal Brompton Hospital. At every stage, from detection to operation, those involved were totally competent and professional. I was kept fully informed of every procedure. There were no delays and every piece of evidence was gained through the use of the most advanced technology available. I witnessed the result of years of investment in the NHS by the previous Government. How dare anyone question the value of the millions of pounds invested? The results speak for themselves and should be celebrated.

My personal journey, just 12 weeks ago, led to an eight-hour operation, carried out by three surgeons, which, I am thankful to be able to tell you, resulted in the complete removal of the tumour and the subsequent analysis that showed it to be non-malignant. I am a very lucky woman. This leads me to highlight one of my main concerns with the Bill: the effect it is having on the morale of those who deliver the service for us. Already in the midst of a pay freeze, with pensions threatened, the impact on existing staff of the threat from the Bill cannot be overestimated.

I saw at first hand the excellence of all parts of the service: the superb nursing staff; the administrators who make the system work; the teams of doctors and surgeons, working co-operatively, who ensure that the service is so outstanding. With GPs and many agencies working together, the service succeeds, but the Bill threatens that very ethos. How will the Bill affect the people involved in my experience, Dr Michael Beckles and his outstanding team at the Royal Free, or Mr Eric Lim at the Royal Brompton Hospital, people who made my recovery possible? Are they going to accept the draconian changes that the Bill inflicts on them or will they walk away and take their outstanding skills elsewhere? That, indeed, would be too high a price to pay and the loss would be immeasurable.

[Baroness Billingham]

No one denies that some rationalisation may be necessary. In fact, some changes are already under way. However, this sledgehammer of a Bill is blind to the fact that the quality of the service is dependent upon the people who work in it. To suggest that market forces, competitiveness—yes, and even greed—are a solution to the NHS's problems is nonsense. So I add my plea to the Government: think again. Listen to the knowledgeable critics and do not destroy the NHS, which has been an icon for the British people. Unless you do, you are wilfully signing the death warrant of the NHS and for that you will not be forgiven.

1.52 pm

Lord Mawson: My Lords, I am a social entrepreneur who, for 25 years, has danced with the dinosaur-like structures of the NHS. I have had my feet trodden on many times, as colleagues and I have attempted to bring some innovations into primary care. We know from personal experience how difficult it is to bring about a more integrated service and innovation within such bureaucratic and out-of-date structures. The vested interests in the BMA and elsewhere in keeping things unchanged and unchallenged are considerable. At the same time, a nostalgic view of the NHS prevails which is anti-business, but which fails to recognise that most GP practices are small businesses and always have been. Let us be honest. I, for one, wish the Government well with their difficult task in bringing much needed change to the NHS.

While many colleagues will have a lot to say about the new proposed structures in primary care, I will make a few simple but fundamental points that appear to have been overlooked. In my experience, trying to change very large organisations—in this case one of the largest in the world—takes time and a great deal of patience. It will involve getting behind those more entrepreneurial doctors who embrace innovation and a more integrated view of the world. In the experience of my medical colleagues, the offer of the biomedical model alone in primary care is too limited an approach for the kinds of health needs that are presented daily. A more integrated and holistic approach is needed, one which sees a human being as not just a bio-medical machine but a fully rounded integrated person set within a social context. Yet many GPs who are committed to positive changes and who are working with the Government to attempt to bring them about are feeling bamboozled by the torrent of paperwork that is being thrown at them by out-of-date anachronistic structures which only know one game—the old game.

In a culture where people are increasingly, through the use of technology, living in an integrated world where at the push of a button many choices present themselves, it will be difficult for this new generation of entrepreneurial GPs to create a flexible structure and innovative culture in the NHS, which is still dominated by silos and an ideology of health inequalities—an ideology which sounds very fine in theory but which, in practice, has many unintended practical consequences that do not favour the patient.

The entrepreneur Steve Jobs, founder of Apple, who has just died knew that technology can be the way into culture change and his technology has created a wholly new generation who no longer want silo-like responses to their problems but at the touch of a button to find an integrated solution.

I would like humbly to suggest a few small simple innovations that the GPs I work with inform me could make an enormous difference to both practice and culture as we seek to push the NHS forward. I have found that the way into large, seemingly immovable structures and organisations, as an entrepreneur, is often through small, simple things that make a big difference. I therefore ask the Minister the following simple, but vital, questions. First, why has the iPad not been used in hospitals and by GP practices and district nurses as a simple integrated communications tool? Secondly, why is it that a GP in Tower Hamlets cannot Skype a consultant in the London Hospital with the patient by their side? Everyone is increasingly using Skype in the real world to communicate and it is free. My medical colleagues tell me that 99 per cent of their patients see no problem with confidentiality rules. We need to remove a system and ideology that makes simple, obvious tasks so complicated. Thirdly, why is it that chest X-ray forms are different everywhere you go in the country. Why are they not uniform and available everywhere online? Fourthly, why have neither the Department of Health nor NICE produced a standard referral form for all types of referral to hospital?

I am a great supporter of the Government's decision to go local, but as an entrepreneur I know, as do my GP colleagues, that there is a whole raft of things that do not need to be developed in every part of the country. It is too expensive and unnecessary. I am told that there is a whole raft of rules stopping the modernisation of the NHS. When innovators like me attempted to cut through these rules in East London in some of the poorest housing estates in Britain, I was told by some at the time that the sky would fall in. It did not and the offer to patients improved. This institution desperately needs innovators, not more bureaucrats.

My colleagues and I are attempting at this time to build a new health centre in one of the most difficult housing estates in London—and here I must declare an interest—which is part of an integrated project on a particular estate that includes both a new school and 500 new homes. Every key partner is supporting the project but it is the outdated, overly bureaucratic systems and processes of the PCT that are simply getting in the way. There are some good people in this PCT, but I cannot imagine how they keep their sanity in such structures. I know this is a widespread problem as many people are retiring early across the country and there is far too much sick leave in the NHS. Ill structures make people ill.

How do we make the simple things happen that catalyse the changes that are necessary and make it worth coming to work for? How do we modernise the NHS and give GPs the tools to do it? I suggest that some of this is about enabling them to just use the simple tools of technology that you and I use every day. It is about giving civil servants permission to get behind innovators.

I would like to leave your Lordships with a final clue. Steve Jobs at Apple did not go around asking all his customers what they wanted. He did not consult them to death. He believed that if the product was

good enough for him, it was good enough for them. The real test for those who oppose this Bill is: would you walk into the average inner city London GP practice and register yourself as a patient? Would you as a patient rank the quality of care provided there as high? If the answer to these two questions is no, then you need to embrace change within the NHS. Jobs achieved what few politicians do. He embraced entrepreneurship and innovation and created real and sustainable change. He focused on creating small innovations in technology that worked well, and then offered them to the world. On his sick bed, he showed a commitment and attention to detail that I have yet to see in many politicians and civil servants. The easiest way into the NHS impasse is simply to back those GPs and nurses who are not threatened by this new emerging world but who embrace it and grasp it with both hands.

We must back the innovators with a sense of purpose. Learn from those who make change happen. Is change going to be difficult? Will this Government get some things wrong? Yes. Innovation is always like that. The question is: can the organisation learn from mistakes? Can it learn by doing? Can it start walking instead of talking? You cannot hold back the ocean; let it flow.

2 pm

Lord Ribeiro: My Lords, I am pleased to follow the noble Lord, Lord Mawson, with his robust defence of entrepreneurship and innovation. The Health and Social Care Bill presents a once-in-a-lifetime opportunity to deliver a patient-centred health service. The Bill builds on the reforms of the last Labour Administration, but in a much more comprehensive manner. As a surgical registrar at the Middlesex Hospital in 1972, ward rounds consisted of doctors, nurses, physiotherapists, social workers and the lady almoner. Coffee in the sister's office provided an opportunity to plan the progress of patients from hospital to home care and support in the community. This was an example of hospital care working closely with social care. Subsequent reviews and reforms of the NHS have entrenched the separation between social care and health care, and this Bill addresses a need for an integrated service led by clinicians who should have a greater say in how the service is commissioned and delivered, but must also be prepared to accept the responsibility and accountability that this autonomy provides.

For too long, political interference in the day-to-day management of the NHS, occasioned by the need for politicians to account for taxpayers' money, has bedevilled the NHS. Micromanagement and top-down diktats imposing targets and guidance, often with no sound clinical evidence to support them, have frustrated clinicians over the years, stifling leadership and innovation. I should know, because I have often been at the receiving end. The emphasis placed on quality outcome measures by the noble Lord, Lord Darzi, as he eloquently outlined today, and in his NHS review of 2008, indicated for the first time a move from politically driven targets which were process-based to evidence-based practice supported by research.

The Government's White Paper *Equity and Excellence: Liberating the NHS* was widely welcomed in July of this year by the profession. It noted that:

"The primary purpose of the NHS is to improve the outcomes of healthcare for all".

It went on to say:

"Building on Lord Darzi's work, the Government will now establish improvements in quality and healthcare outcomes as the primary purpose of all NHS-funded care".

Clause 2 does just that. It talks about outcomes, the effectiveness of the services, measured by clinical outcomes and patient-reported outcome—something which is already happening within surgery, the safety of the services and the quality of the experience undergone by the patient. The inclusion of research as a new duty for the Secretary of State puts an onus on him or her to promote the use of evidence obtained from research, a duty which also relates to the NHS Commissioning Board and the clinical commissioning groups. Other noble Lords will, I am sure, speak about the importance of research, but it is important that the Chief Medical Officer who, as the Chief Scientific Adviser and Director of the National Institute of Healthcare Research, must be given the independence of action to ensure that the Commissioning Board and the clinical commissioning groups take account of the evidence of research.

In a debate on the NHS Futures Forum on 15 September, I raised the issue of the independence of the Commissioning Board and the need to free it of political interference. I referred to the King's Fund report *Reconfiguring Hospital Services* as an example of how hospital services can be reconfigured without political interference, making reference to the experience in Ontario. The decision to close the A&E and maternity services at Chase Farm was an example of how the evidence for reconfiguration has been available for many years—17, I believe—but the political will to use it was lacking. Freed of such pressure, the Commissioning Board should be able to make decisions which politicians find difficult to make, even when the evidence for change is there for all to see.

The White Paper also called for clinical leadership and this was echoed by the Future Forum. Now is the time for the medical profession to stand up and be counted. The Royal College of Surgeons, of which I am a Fellow and a patron, has said very firmly that the time for delay has passed. It is nine months since the Bill was first read; an in-depth review by the Future Form, taking evidence from more than 7,000 people and receiving 25,000 email comments, has been accepted almost entirely by the Government and many amendments reflecting their concerns are now included in the Bill.

As a surgeon, I am aware that we must do more to deal with the demand for healthcare. Much of this relates to public health. The problems relate to obesity. Britain has among the worst levels of obesity in the world and it is increasing. Smoking claims over 80,000 lives a year, and alcohol dependency is a problem for 1.6 million people in the UK. These are all public health issues which put enormous strain on the capacity of the NHS to cope. Diabetes, cardiovascular disease, respiratory diseases and cancer are some of the non-communicable diseases which are on the increase and they require prevention rather than cure.

Public health, in the form of clean air, clean water and sanitation and vaccination against communicable diseases, improved the health of the nation during the

[LORD RIBEIRO]
last century. It has increased the quality and the extent of life. We need to make provision for our elderly population, through greater integration of our health services, dealing with social care as well as acute care, and focusing on a care pathway, not just the condition. The Secretary of State's responsibility for public health is welcome and is a clear indication that the Cinderella service has come of age and can take its place alongside acute care in terms of the total care of the patient.

Like many noble Lords, I have received countless emails about today's debate. An abiding theme is privatisation and the Americanisation of our health service and the threat of cherry-picking by American companies. It might be helpful to put the term "cherry-picking" in context. It was first used in a submission I made as president of the Royal College of Surgeons to the Health Select Committee of the House of Commons when we were meeting on the independent sector treatment centres in February 2006. On 10 January 2006, the Secretary of State said of the independent sector:

"But I recognise that other reasons for using the independent sector to add to the innovations already happening within the NHS and to introduce an element of competition and challenge to under-performing services is a harder argument to win, so we will continue to respond to legitimate concerns, for instance to ensure that training for junior doctors is provided within the independent sector treatment centres"—

that still has not happened—

"and more generally to provide a level playing field for different providers within the NHS".

That was five years ago. In my oral submission to the Health Select Committee on 9 March 2006, I welcomed the Secretary of State's statement as it sought a level playing field. "Any qualified provider"—with the emphasis on "qualified", as the noble Baroness, Lady Jay, required—seeks to ensure that competition within the NHS will be fair. It is not a new concept and I believe that the Bill addresses the concerns raised in 2006. In Committee, I will seek to explore in more detail how post-operative complications arising from surgery by qualified providers will be managed, to ensure that they do not place an unfair burden on the NHS. For many years, the medical profession has called for an end to top-down management, targets and political diktats on health, and they remain frustrated with the workings of the PCTs.

This Bill heralds a shift from central command and control to patient and professional power. It provides an opportunity to improve health outcomes for patients and remove layers of bureaucracy which have built up, at great cost to the NHS. No change is not an option. Doing nothing will see health costs rise to £130 billion by 2015. We need to act now to safeguard the NHS for future generations.

2.09 pm

Baroness Williams of Crosby: My Lords, I agree completely with the noble Lord, Lord Ribeiro, that major changes have to be made. Those of us who are raising major issues in this debate are not arguing against change; we are not bound to the status quo. But I want to say right away that one of the things that I find deeply depressing about this long debate on the National Health Service is the number of references to the NHS as if it has somehow failed. One of the most remarkable assessments of the NHS, a copy of which I have left in the Library, is made in a report by the Commonwealth Fund of Massachusetts. It shows that on every issue from access, value for money, share in expenditure and patient satisfaction—which achieved 92 per cent—puts Britain uniquely ahead of everyone else in reply to the question, "Are you confident that you will receive the most effective treatment if sick?". It is a staggering statement about this remarkable public service.

First, I want to underline and repeat what was said by the noble Baroness, Lady Jay. Those of us who take the view that this Bill needs to be looked at carefully, not least the issue of the responsibility of the Secretary of State, are not saying for a moment that there is no role for the independent sector, for innovators or for those with radical ideas, but straightforwardly that that must be within the framework of the National Health Service as a public service, which is what many of us believe in so profoundly.

My second point is one that I also believe to be very important. We have referred repeatedly to patients in the debate, but patients are also people. As people, they have registered time and again their belief and trust in and commitment to the NHS. We want to carry them with us through some of the biggest changes that have to be made. Those changes reflect our ageing population, which is one of the greatest successes of the NHS, along with the survival of many people with inherited or chronic illnesses. All this can be directly attributed to the work of the NHS over the past 65 years. However, now they have become a problem because we have to find ways to pay for them. Even so, they are a direct consequence of success, not of failure.

What also needs to be said loud and clear is that patients have indicated their trust in the NHS. We need that trust deeply in order to bring about the changes that must be made. I agree with the Minister, the noble Earl, Lord Howe, that those changes require that the NHS should become, among other things, more community based and that we should move away from an essentially curative, hospital-directed form of health service. But in making that huge change with all the exciting possibilities it offers, we have to carry the public of England with us. We will not carry them if their single greatest fear appears to be sustained. It was put beautifully this morning by the noble Lord, Lord Hennessy, on the "Today" programme: it is to move away from the concept of an altruistic health service to one that is essentially market based.

I have spent the past week in the United States and returned yesterday. The first thing I read when I got there was the estimate of the Kaiser Family Foundation, probably one of the best of the private health services in the United States, that the cost of health insurance has doubled since 2001, has increased by 9 per cent since last year—much more than the rate of inflation—and that the average cost of a family insurance package in 2010 was over $15,000. Not all of that is paid by the insuree as some is paid by employers, but they are running away from those costs as fast as they know how. I also read a proposal from the National Institutes

of Health that great care should be taken about offering tests for prostate cancer in men when one of the side-effects is probably incontinence and impotence. Despite the advice of the central authorities, the attitude of many doctors is that they cannot give up these tests because they happen to be extremely profitable. For those who wish to read more about it, I have left the story in the Library. It is a frightening account of the conflict between medicine and its values and the pursuit of profit.

I turn now to the four big issues that confront us, and in doing so I pay tribute to the noble Lords, Lord Darzi and Lord Owen, and to others who pointed to them. The first was referred to by the noble Baroness, Lady Jay. It flows from the findings of the Constitution Committee, which has specifically raised concerns about the responsibility of the Secretary of State. At the beginning of his remarks, the noble Earl, Lord Howe, whose empathy and understanding is known throughout the House, spoke as if there might still be some meeting of minds on this crucial issue. But the letter he sent us all this morning appears to sound a little different. Why are we so concerned about this issue? It is because it remains ambiguous, unclear and obscure. Let me give one example. I think that I have been pursuing the issue of the accountability and responsibility of the Secretary of State for at least a year, and time and again I have gone back to the Department of Health and talked about the need to make it absolutely clear. Why is it not absolutely clear?

Those noble Lords who have a copy of the Bill need only look at Clause 4, which sets out a specific commitment to the autonomy of the bodies, the quangos —Monitor and, even more important, the NHS Commissioning Board—which now have responsibility for our health. The Secretary of State makes a specific pledge to the autonomy of those bodies in the phrase:

> "In exercising functions in relation to the health service, the Secretary of State must, so far as is consistent with the interests of the health service, act with a view to securing … that any other person exercising functions in relation to the health service … that it considers most appropriate, and … that unnecessary burdens are not imposed on any such person".

In legal language, "any such person" is very wide indeed. The autonomy clause indicates that only in the rarest circumstances would the Secretary of State interfere in that autonomy. So where would he interfere? The answer is that he would interfere if there was evidence of a significant failure. But my legal colleagues tell me that "significant failure" is a difficult bar to reach and that it is normally interpreted by the courts as meaning almost totally essential.

We all know about the danger of reactions to such things as necessary hospital closures, mergers and so on. But if the Secretary of State is unable to take any part in those until the failure becomes significant, heaven help us in making the changes that lie in front of us as effectively, cheaply and sensibly as we can. I wish very much that I could ask the Minister of State to tell the House at the conclusion of this debate that the ministry will now reconsider the autonomy clause in the light of the responsibilities of the Secretary of State. To put it simply, the expenditure of £128 billion of taxpayers' money requires the presence of a Minister who is responsible and accountable for that huge sum. It is an essential part of parliamentary responsibility and of a democratic system. I fear the consequences if we fail to address this issue.

That does not mean to say for a moment that I do not wholly agree with the noble Lord, Lord Ribeiro, about the dangers of micromanagement; all of us recognise that. Endless interference with the discretion of clinicians, GPs and the professions ancillary to medicine runs against the need for change and for sensible outcomes. But there is no reason whatever why micromanagement cannot be ruled out—much of the rest of the Bill suggests it—without having this vast reorganisation thrust upon us. So let me say to the Minister of State, for whom I and the rest of the House have immense respect, that I hope that before the debate concludes he will be able to say something more about the autonomy clause and the responsibility clause.

There are several other issues of crucial importance: the failure of the Bill to address the education and training of doctors in any serious way at a time when those services are in chaos, and the Bill's failure actually to be clear about the duties towards inequality, because the phrase "have regard to" is, in legal parlance, paper white. It does not mean very much at all. There are other points, but given the time I will not pursue them. I simply beg my friends and colleagues on whatever Bench they may sit on in this House to put the responsibilities of parliamentary democracy and accountability ahead of the detail of the Bill and recognise the significance of what has been addressed by the noble Lord, Lord Owen, and the noble Baroness, Lady Jay.

2.20 pm

Lord De Mauley: My Lords, I suggest that it may be convenient for the House to adjourn until Questions at half past two.

Debate adjourned.

Sitting suspended until 2.30 pm.

Regional Growth Fund

Question

2.30 pm

Asked By ***Lord Harrison***

To ask Her Majesty's Government what steps they are taking to encourage small businesses by revisiting the qualification threshold for the regional growth fund and by establishing a small business bank created with initial bonds funded by the Monetary Policy Committee.

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): My Lords, we see no need to revisit the qualification threshold for the regional growth fund. In round 1, a third of funding allocated—some £150 million—was targeted at SMEs. It is not the job of the Monetary Policy Committee to establish a

[BARONESS WILCOX]
small business bank; there are more efficient ways of supporting small businesses, such as the Merlin commitment and the enterprise finance guarantee scheme. My right honourable friend the Chancellor of the Exchequer has also announced that he is considering credit easing options and will make further announcements on this in November.

Lord Harrison: My Lords, the Government seem more interested in giving cheap phone access to Ministers for big businesses than getting cheap loans access to small businesses that are starved of funds. I ask the Minister again to look at the regional growth fund, the qualification for which is a £1 million claim by any small business. I ask her to look at some fresh ideas, like those of Professor David Blanchflower, for creating within the Bank of England, through the MPC, a bank which is capable of offering loans to small businesses at low rates of 2 per cent.

Baroness Wilcox: If the noble Lord will wait for the Chancellor of the Exchequer to explain what he is going to do about credit easing, the noble Lord might take comfort from that. In the mean time, there is no doubt that the fund is accessible to SMEs; it is available through specific bids from organisations with experience of the SME sector that will be able to help make small grants, below £1 million, available to projects that support the fund's objectives.

I have a couple of examples which might help. The Plymouth University and *Western Morning News* growth fund was announced in the summer, which targets that money directly at SMEs in the south-west of England. That will work well. Contracts have recently been finalised on the majority of engineering projects in the RGF-supported SME energy cluster in the north-east, headed by Chirton Engineering Ltd. That will be delivering 140 jobs. Although £1 million sounds too high for a small organisation, it would have been impossible to look at every one of those small applications. If anyone wishes to phone the regional growth fund, they will be helped and guided as to how they can come together with other small businesses to take this money. As your Lordships can see, we have already made available some nice amounts of funding—almost a third—to the SMEs.

Lord Howarth of Newport: My Lords, we certainly look forward to the Chancellor of the Exchequer explaining what he intends by credit easing. Would it not be the case that credit easing would tend to increase the public sector deficit to the extent that Government-backed loans to small and medium-sized enterprises underperformed? What would be the costs to SMEs in professional fees and regulatory burdens of issuing bonds? Is not the proposal to package up, securitise and sell into the marketplace loans to SMEs that banks are not otherwise willing to make all too reminiscent of the US sub-prime disaster?

Baroness Wilcox: I have listened carefully to what the noble Lord has said, but, as he well knows, I cannot say anything in response at the moment because the Chancellor of the Exchequer has not expounded on how he is going to bring this forward. No doubt the noble Lord will ask me a question again when the Chancellor has done so.

Lord Cotter: My Lords, manufacturing accounts for 12 per cent of GDP but 50 per cent of our exports. Can I ask the Minister to give an assurance that the Government will concentrate in the future on financial support for manufacturing, which is very complex—there is a need for seed capital and a need for support for research and development in new technologies in particular. There is also great concern that the private banking sector is not sufficiently delivering on lending, which is a disappointment following the Merlin initiative.

Baroness Wilcox: The ECGD covers all of that, of course. Today I am delighted to say that the Government are funding manufacturing research in a drive for future growth: a £170 million package to sharpen the UK's competitive edge has already been given out; a high-value manufacturing technology and innovations centre is receiving £140 million over a six-year period; and the TSB and the Office for Low Emission Vehicles will be running a £15 million competition for investment into the research and development of low-carbon vehicles. I am delighted to be able to announce that today.

Baroness Wall of New Barnet: Can the noble Baroness give us any more details on the Government's intention to support the BAE Systems workers? She will know that it was announced earlier this year that 3,000 workers were to be made redundant and that, in both Yorkshire and north-west England, very highly skilled people are being displaced as a result. The Government promised support. Please can you update us on that?

Baroness Wilcox: We have of course created a new enterprise zone in that area especially for this. These are terrible times, and the idea of seeing any jobs go at the moment, certainly in the private sector, goes against everything we wish for growth. That enterprise zone is there and we will put every help we can into that area. The Government's economic policy objective is to achieve strong, sustainable and balanced growth that is more evenly shared across the country and among industries. We will therefore look very carefully at any other incidence of this happening.

Lord Roberts of Conwy: Is my noble friend satisfied that there is sufficient demand for loans on the part of small businesses?

Baroness Wilcox: It is quite amazing how much demand there is from small businesses for loans. The great thing about small and medium-sized businesses is that they tend to be very optimistic. I grew up in the world of small and medium-sized enterprises, where, against all the odds, you would very often see someone setting up a business in an area where everybody else said it could not possibly have happened. Yes, we are very encouraged by the amount of requests we are getting.

Baroness Royall of Blaisdon: My Lords, in her answer to my noble friend about what the Government are doing to assist those workers who were so tragically being made redundant from BAE Systems, the Minister mentioned local enterprise zones. Can she tell us exactly what the local enterprise zones are going to do to assist in finding jobs and supporting small and medium-sized enterprises in those areas of the country? Would it not have been better to have retained the RDAs?

Baroness Wilcox: The RDAs were enormously expensive and were not value for money. I am very glad that we are finished with the RDAs, although one or two of them were extremely good. I hope that the local enterprise initiatives will enable people to take themselves forward so that they do not always turn round and depend on the Government, which is not a good way to take forward the private sector—the sector that will actually start to bring our country out of this deep depression that we find ourselves in.

Multiculturalism

Question

2.38 pm

Asked By ***Lord Harries of Pentregarth***

To ask Her Majesty's Government what is their definition of multiculturalism and what is their policy towards it.

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham): My Lords, the Government do not have any particular definition of multiculturalism. They welcome the strength that the people of many nations, religions and cultures who live in this country derive from their common heritage. By sharing and understanding these differences in our communities, we can draw on the full range of their talents and find those things that unite us. Segregation for any reason is contrary to the need for all communities to integrate and live together in harmony.

Lord Harries of Pentregarth: I thank the Minister for her reply, but would she not agree that it is very important to have a clear definition? In an important speech in Munich earlier in the year, the Prime Minister mentioned multiculturalism in a key paragraph but gave no definition of it. However, he implied by the end that it encouraged separate development. Multiculturalism is what philosophers used to call a "boo word", or "hurrah word", so would it not be helpful for everybody if the Government had a very clear definition and made clear what they approved of and what they did not approve of?

Baroness Hanham: My Lords, in talking about people living together and communities coming together, it is very hard to say what one approves of and what one does not approve of. It is absolutely essential that we all understand that in this country we have an enormous number of different nationalities and cultures. The one way we can be sure that we will live together is by understanding the nature of those cultures. When I say there is no definition, there is no definition but, in thinking about it even faintly, one would say that multiculturalism is the coming together of communities and the recognition of those differences.

Lord Popat: My Lords, does my noble friend agree that, while cultural diversity and tolerance towards other cultures and religions is a good thing, the Government's position as set out by the Prime Minister —in Berlin, not Munich—of supporting an overriding and unifying national identity and not appeasing or supporting extremist organisations who undermine British culture and values, is the right approach?

Baroness Hanham: My Lords, I think that is what I have been trying to say in my two previous answers. The Government are fully aware of the tensions that there can be between communities; they are extremely anxious to see that those tensions are lessened and will use whatever methods they can to make sure that integration comes about and that people are content to live together in this country which, on the whole, has been blessed with fewer tensions than elsewhere.

The Lord Bishop of Blackburn: My Lords, my own responsibility includes Burnley which, some 10 years ago, had its own local disturbances. Therefore, I welcome all moves towards greater multicultural working, especially through the near neighbours scheme that has recently been introduced. Could the Minister confirm that, subject to satisfactory assessment when the three-year trial period for the near neighbours scheme has expired, the scheme will continue?

Baroness Hanham: My Lords, it is a three-year scheme, so at this stage I cannot absolutely confirm that it will continue, but I can confirm that we attach enormous importance to it and are extremely grateful for the church's involvement in that fund. We will certainly want to assess its results. Following its successful launch this summer, we are going to scale up the scheme next year to give up to 30,000 16 year-olds the chance to meet with young people from different backgrounds. The church is providing a very strong lead on this.

Lord Hannay of Chiswick: My Lords, would the noble Baroness agree, having wisely ducked the request to define multiculturalism, that it might really be better if everyone including Ministers—and including the Prime Minister—stopped talking about this as an "ism" at all? It is utterly misleading to do so. It would surely be better, as I think the noble Baroness has started to do in her replies, to address the issues, in a society that is necessarily, and will continue to be, multicultural.

Baroness Hanham: My Lords, "ism" or not, the word is in the vernacular one way or another. I do not think it matters whether it is an "ism"; it matters what we mean about trying to ensure that people are supported in their own cultures so that, by definition, they are

[Baroness Hanham]
made—not made, but supported—to integrate into this community. We are perhaps still, despite what has happened recently, one of the most tolerant societies. We have one of the largest numbers of nationalities living here and, however one defines it or whatever one says—multicultural or multiculturalism—we know what we mean and understand that what we mean is trying to provide a homogeneous community.

Baroness Hussein-Ece: My Lords,—

Lord Knight of Weymouth: What is the Government's policy towards multiculturalism in schools? Given the current concerns about the curriculum being squeezed out by the EBacc, is the noble Baroness in conversation with Ministers in the Department for Education about making sure that there is room in the curriculum for citizenship and that schools are continuing to promote community cohesion, as is their statutory duty?

Baroness Hanham: Schools have a statutory duty to support cohesion, and I think most schools do that. One of the most important aspects of bringing up children in this community is that they should speak English. There is a very strong commitment to ensuring that children are given English lessons at an early stage to ensure that they can not only participate in school but understand where their friends who are living here are coming from.

The Department for Education will answer for itself about citizenship, but I can say that we will continue to fund classes that encourage English. In general, we think that one of the biggest strengths that comes from multiculturalism is speaking English, which is the common language. We should bear in mind that people will want to continue to support their own ethnic languages, but they must do that in a way that ensures that their children and, where possible, the elders all speak English.

Asylum Seekers

Question

2.46 pm

Asked By ***Baroness Bakewell***

To ask Her Majesty's Government, in the light of the number of asylum decisions overturned on appeal, in particular among female asylum seekers, what steps they are taking to ensure that women fleeing gender-based persecution receive fair asylum decisions.

Earl Attlee: My Lords, the Government recognise that women can face particular forms of persecution that are quite often different from those faced by men, and are committed to ensuring that women's claims for asylum are dealt with as fairly and sensitively as possible. The UK Border Agency is working closely with a range of key corporate partners in developing improvements to the asylum system. This will increase gender awareness throughout the asylum process.

Baroness Bakewell: I thank the Minister for his reply, and for implying that there is still space for improvement. Perhaps he knows the case of the playwright Lydia Besong, who sought asylum here in 2006 having been imprisoned and raped in Cameroon for being a member of the Southern Cameroons National Council. She has been refused asylum and is under threat of removal. Does the Minister agree that women such as Lydia—and there are several—who suffer gender-related persecution should be protected rather than sent back to face further risk, and that early access to legal representation for appeal would reduce the costs of the asylum process?

Earl Attlee: My Lords, Miss Besong is a failed asylum seeker, having had her appeal and further submissions dismissed by the courts, not by UKBA. She became appeal rights exhausted this year and therefore subject to enforced removal action if she refuses to leave the UK voluntarily. On the noble Baroness's second point, about leaving it to appeal, it is open to legal and other advisers to introduce new evidence to the UKBA at any point between the original decision and the appeal hearing. Asylum could then be granted before the appeal is heard. It is not clear to me why this does not happen more often.

Lord Avebury: Does the noble Lord accept that at the asylum stakeholders' meeting on 4 August the UKBA said that it had not released any victim of gender-based violence from the detained fast-track and did not consider it a reason for releasing a person? Is this not a breach of the undertaking that was given to the High Commissioner for Human Rights at the Council of Europe that:

"Particularly vulnerable applicants including … victims of trafficking or sexual violence … are not dealt with within the DFT process as a matter of policy"?

Does my noble friend accept that as the success rate of appeals by women against refusal of asylum is running at 50 per cent, it is clear that the improvements in procedures for dealing with gender-based violence in the criminal justice system have not read across to the UKBA?

Earl Attlee: My Lords, I think I have already explained why there can be very good reasons for the overturn rate at appeal. As regards the noble Lord's question about detained fast-track, I am confident that legal protections for the detainee must be in place, but I shall write to the noble Lord on that point.

Lord Martin of Springburn: My Lords, there were more asylum seekers in my previous constituency of Glasgow North East than in any other part of Scotland, with 90 per cent of the cases at my surgery being asylum seekers. They were made most welcome by some of the poorest communities in the United Kingdom, but should there not always be monitoring in these communities to ensure that enough resources are going in to help where there is strain on local health services, schools and housing departments?

Earl Attlee: My Lords, the noble Lord makes an important point about the need for care. One reason why you see concentrations of certain nationalities in certain places is that communities tend to become established, and it is natural for asylum seekers to go and join their own community in the UK.

Baroness Kennedy of The Shaws: My Lords, perhaps I may return to the issue of gender. The running rate of 50 per cent of women succeeding in appeals, which is almost double that of men, is suggestive that there is poor decision-making and a culture of disbelief at the first instance in relation to women. Is that therefore not a signal, first, that there is poor training and, secondly, that there should be legal representation when the women are first interrogated and questioned because they are having to deal with sensitive matters such as sexual violence?

Earl Attlee: My Lords, I largely agree with the noble Baroness. The problem is that the matters that the applicant has to explain to the UKBA officers are extremely sensitive and the applicant has not yet acquired confidence in the machinery of our state because the machinery of their home state has totally failed.

Baroness Kennedy of The Shaws: Should there not be lawyers present?

Noble Lords: Order!

Baroness King of Bow: My Lords, following on from the noble Baroness's point, is the Minister aware of Asylum Aid research which stated that there was a "striking failure" of understanding what was happening to these women on the part of those making the decisions? Would the Minister be prepared to meet me and other interested Peers to discuss how the UKBA training could be improved? Women deserve better than they are currently getting.

Earl Attlee: My Lords, I entirely agree that women deserve better, and we are working at improving our performance. We are not saying that we are perfect but often new evidence is introduced at a later stage when the applicant becomes more confident or has better legal advice. I shall of course be delighted to have a meeting with all noble Lords who are interested in this matter and I shall take steps to make sure that that happens.

Economy: Growth

Question

2.53 pm

Asked By ***Lord McFall of Alcluith***

To ask Her Majesty's Government what plans they have to develop a growth strategy.

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): My Lords, the simple answer is that this Government already have a strategy. The *Plan for Growth*, published alongside Budget 2011, set out the Government's plan to put the UK on a path to sustainable, long-term economic growth. As my right honourable friend the Chancellor of the Exchequer reiterated last week, we have a credible plan to reduce the deficit and tackle our debts. We are creating the right conditions to enable growth which is driven by investment and exports and is more evenly balanced across the UK and the sectors.

Lord McFall of Alcluith: My Lords, having witnessed almost zero growth during the 17 months of this Government and with pleas from influential Conservative Back-Benchers and sympathetic industry bodies for a coherent economic plan, is it not time for a radical response from the Government to what the Governor of the Bank of England has described as possibly the worst ever financial crisis by the establishment of a national infrastructure and investment bank to generate jobs and employment in this country? I remind the House that we have a duty to the more than 1 million young people in this country—a record level of unemployment not seen since the 1980s—to help them to inherit a worthy future rather than an economic and social graveyard.

Baroness Wilcox: The noble Lord has outlined exactly what we are striving to achieve. Without doubt, we are looking across the whole of the education and skills system to consider how to maximise economic growth and we shall be reporting on that in the autumn. He asks what we have achieved. As I have already said today, the Business Secretary, Vince Cable, has announced a £170 million package to drive future growth in manufacturing; we have reduced the main rate of corporation tax from 28 to 26 per cent and it will go down to 23 per cent; a £2.5 billion business growth fund has been launched; and we have already announced 24 enterprise zones in the country, helping to create thousands of new jobs by 2015, which will attract hundreds of new start-up firms with simplified planning rules, superfast broadband and more than a 150 million tax breaks for new businesses over the next four years. I have a longer list, but I am sure that someone else will wish to ask a question. I hope that the noble Lord feels encouraged by my answer.

Lord Low of Dalston: My Lords, is it not the case that the Government have got their policies in the wrong order? Instead of pursuing deficit reduction in the short term and growth in the medium to longer term, should they not be pursuing growth in the short term and deficit reduction in the medium to longer term?

Baroness Wilcox: Reduction equals low interest rates, my colleague beside me murmurs. Without doubt, we are trying to get Britain back on track. It will take time, but we are determined to do it deeply and well. The *Plan for Growth* is based around four ambitions: creating the most competitive tax system in the G20; making the UK the best place in Europe to start, finance and grow a business; encourage investment and exports as a route to a more balanced economy;

[Baroness Wilcox]
and creating a more educated workforce that is the most flexible in Europe. We are the first to start that; we were one of the first to go into this recession; and, with this Government in charge of this country, we will be one of the first out.

Lord Haskel: My Lords—

Lord Forsyth of Drumlean: My Lords, is not the truth of the matter that it is extremely difficult to get growth in a situation where half the national income is being spent by the Government and the national debt has been doubled in every Parliament? That is the inheritance which this Government have been handed. Has my noble friend seen the ideas put forward by Sir Brian Souter, who started with nothing, but a loan from a parent, and who has built a major business in our country? He suggests that the enterprise allowance scheme should be extended so that loans that are provided by relatives are eligible for the scheme. As almost anyone who starts a business knows, it is very hard to get money other than from a relative, and yet they are excluded from the scheme. Is this not an idea that could actually make a difference?

Baroness Wilcox: I am very interested to hear what my noble friend has said. We are looking at all sorts of ideas to start bringing us forward. As you say, Brian Souter would have said, "Get on your bus", not, "Get on your bike".

Lord Campbell-Savours: My Lords—

Lord Barnett: If the noble Baroness cared to have a word with her noble friend Lord Sassoon, who is sat next to her, he would explain that there is no chance whatever of her growth strategy working while the deficit reduction plan is so inflexible. As the noble Lord, Lord Low, has said so well, without growth we have a growing deficit. Please have a word with the noble Lord, Lord Sassoon. If he is being honest, he will tell the noble Baroness the truth.

Baroness Wilcox: I am very lucky indeed to have a colleague like my noble friend Lord Sassoon to work with and to depend on. The *Plan for Growth* lays the foundations for a stable and rebalanced economy. As the Prime Minister said last week, we have a plan to achieve strong, sustainable and balanced growth and we are sticking with it.

Lord Higgins: My Lords—

Lord Newby: Does the Minister agree that Whitehall has a very poor track record in getting major infrastructure projects moving forward expeditiously? Can she therefore tell us what steps BIS is taking to support the initiative of the Chief Secretary to kick start 40 major infrastructure projects?

Baroness Wilcox: He is doing everything he can. It is a good question and I am happy to respond to it. We are obviously committed to an export-led recovery, which is important to us. The *Plan for Growth* and the Trade and Investment White Paper have set out how we can better exploit opportunities in this area. I shall respond to the noble Lord's specific point in more detail.

Lord Higgins: My Lords—

Lord Campbell-Savours: My Lords, are there any lessons to be learnt from the early 1930s when public expenditure was cut?

Baroness Wilcox: We are making policies for now, looking forward. I am not sure, looking backwards, that there are too many lessons to be learnt from recent years.

Lord Higgins: My Lords, third time lucky. I welcome the recent decision to increase quantitative easing since an increase in the money supply is essential if growth is to be sustained. Does my noble friend agree that fears that this will increase inflation need at least to take into account the very high level of excess capacity in the economy, which will be used if the Government adopt a policy of quantitative easing?

Baroness Wilcox: I absolutely agree with my noble friend. Quantitative easing is a positive move to help the British economy. The evidence shows that it should keep interest rates low and boost demand, which will help families, too, at a very difficult time.

Coinage (Measurement) Bill

Order of Commitment Discharged

3 pm

Moved By ***Lord Risby***

That the order of commitment be discharged.

Lord Risby: My Lords, I understand that no amendments have been set down to this Bill and that no noble Lord has indicated a wish to move a manuscript amendment or to speak in Committee. Unless, therefore, any noble Lord objects, I beg to move that the order of commitment be discharged.

Motion agreed.

Health and Social Care Bill

Second Reading (Continued)

3.01 pm

Baroness O'Loan: My Lords, prior to the drafting of the Bill, we had assurances from government that there would be no top-down reform of the National Health Service, a service which is so highly regarded internationally, as the noble Baronesses, Lady Billingham and Lady Williams, said earlier.

The level of concern about this Bill must surely be virtually unprecedented. Representations have been received on a massive scale from hospital consultants, the College of Occupational Therapists, health service managers and, in one case, 1,000 doctors writing to a

daily newspaper. It is important to note the range of people who are expressing concern: the NHS Support Federation, the co-chair of the NHS Consultants' Association and member of BMA Council, Mind, Rethink Mental Illness, the Centre for Mental Health, the Mental Health Foundation, the Royal College of Psychiatrists, councillors, the UK Faculty of Public Health, the Academy of Medical Royal Colleges, Diabetes UK, the Royal College of Nursing, the National Children's Bureau, the BMA, the TUC and so on.

Proposals for change in the NHS are not new. We have had decades of them, and this alone should inform us of the need for sensitivity and strategy in the way in which we approach reform.

The concerns which have been identified are various, but they were well articulated by a senior NHS director of public health, who wrote:

"The Bill will do irreparable harm to the NHS, to individual patients and to society as a whole. It ushers in a significantly heightened degree of commercialisation and marketisation that will fragment patient care; aggravate risks to individual patient safety; erode medical ethics and trust within the health system; widen health inequalities; waste much money on attempts to regulate and manage competition; and undermine the ability of the health system to respond effectively and efficiently to communicable disease outbreaks and other public health emergencies".

In the creation of the internal market so many years ago, we saw change of a much lesser kind, and it resulted in the creation of hundreds of new bodies which accelerated the cost of NHS administration over the years. I sat on a health board at that time and recall vividly the perplexity and inefficiencies which resulted. Those changes had to be undone at immense cost. There is significant concern that the current proposals are even more unthought-out in their formation. We cannot afford unplanned and ill-thought-out change at a time of economic turbulence with the ongoing threat of global recession.

The NHS is not broken; it is simply being tasked to carry out more and more work for a rapidly expanding population, which is also living longer in a world in which science is providing the answer to many medical problems which were previously insoluble. All this involves rapidly increasing costs. Nobody denies that more resources have been put into the NHS. What is necessary is that we acknowledge that the NHS is meeting huge levels of demand and that will not change.

The proposal in this Bill is that the Secretary of State will no longer have to account to Parliament for the delivery of a service that is key to the United Kingdom's economic, financial and social stability. There will be new structures for service delivery, for example, which will permit Monitor to determine that an NHS provider is not meeting the needs of its service users and to use taxpayers' money to buy those services from the private sector. This is effectively unplanned, unstructured privatisation, with the attendant enormous difficulties of regulation. Regulation is no substitute for good governance structures and planning.

The complexity of national demand—of access to clinical specialities and training and management change required by the Bill—are as yet unquantified. The potential for challenge in the courts in the context of service delivery are enormous. This will involve more loss of resources for the delivery of patient care. I have great concern over the proposal to place primary responsibilities with general practitioners who face monumental challenges simply in staying up to date with developments in clinical practice across the whole spectrum of health issues. To fragment purchasing responsibility in this way can only add to cost and to the possibility of inequalities in the provision of care. Many of the relevant questions in this context have already been asked in the House today. I will not repeat them.

Undoubtedly an organisation of the size, scope and range of responsibilities of the NHS must be in a constant process of change. What is profoundly important is that reform is carried out following proper consultation with a clear mandate with properly costed and analysed resourcing decisions and with the support of service users—or patients if you want to refer to them that way—and of the professional bodies that will have to implement the change. I have not seen the evidence to suggest that that is the case in the Bill. Its current deficiencies have been and will be widely articulated in the Chamber today. In the interests of brevity, I will save any further comment for the later stages of the Bill. I will simply state my support for the proposal of the noble Lords, Lord Hennessey and Lord Owen, for a Select Committee.

3.07 pm

Lord Patel of Bradford: My Lords, we are faced with only two options in the debate. We can seek to dramatically improve the Bill—and make no mistake, it needs dramatic improvement—or we can reject it out of hand. Neither option is without consequences. However, if the Bill passes through the House without significant amendment, the consequences will be even more severe. Noble Lords who have already spoken have covered many aspects of the Bill which cause all of us concern. I also have serious reservations about the impact of the Bill in a number of areas: on commissioning, public health, integration with social care, service-user engagement and quality and safety. As time is limited, I will focus my contribution today on the implications for mental health services. I declare that I was the former chairman of the Mental Health Act Commission.

We are told that commissioning will improve by being led by doctors and nurses. On the surface it is a reasonable assumption that relies on the simple idea that a doctor or nurse knows best what an individual patient needs. However, there is a problem; commissioning is not done for the individual, but is about the whole community. Commissioning is a process by which decisions are made on the most appropriate level and quality of services for a population. This is not an easy thing to do, as we see very clearly with respect to secondary mental health services and, particularly, specialist mental health services. It is widely acknowledged that this has been one of the weaker aspects of PCT commissioning over the past few years. However, the Bill as it stands can only make matters worse.

What is really worrying is the potential for confusion about roles and responsibilities for disputes in funding decisions. Oversight of service providers and commissioning will lie with the newly created NHS Commissioning Board, but local commissioning of many mental health services will be done by clinical

[Lord Patel of Bradford]
commissioning groups. Will this make services better? I think not—especially not when care is provided upon the basis of a generalised tariff established by Monitor for what a care episode can cost. This is a system that seems designed to fail the most complex and difficult cases.

I am in agreement with the Law Society, which states that:

"The separation of commissioning responsibilities for mental health services could lead to divergence in strategy and commissioning intent, and increase commissioning disputes to the detriment of service users".

But it is not just the confusion in commissioning that makes me concerned. I am also worried about the implications for continuity of care planning. One of the most important things that we could get right in psychiatric services is care planning. You can see this from almost any inquiry report into the deaths of psychiatric services users, or into a homicide involving a service user. But to plan care in a holistic way, you need to have a holistic service and the Bill appears to create conditions where such joined-up services will be ever more difficult to achieve.

That is especially so with respect to aftercare and I have grave concerns about the amendments proposed to Section 117 of the Mental Health Act 1983, which concerns the provision of aftercare once a detained patient is discharged from hospital. I cannot see how patient care will be improved by the amendment that either the health or social care partner in the provision of aftercare can unilaterally decide to withdraw from the provision of services. But most worrying, the amendments seem to be designed to enable the charging for services provided to patients who have been detained under the Act.

The Law Society has quite correctly called for this to be prevented through an explicit statement in the Bill. It is nearly a decade since the Appellate Committee of this House, in the Stennett case, recognised some sort of reciprocal aftercare duty towards those whom the state has detained for healthcare reasons. In many cases, continued engagement with aftercare services is a de facto condition for discharged patients—are we to support patients being charged for services that are imposed on them?

What about the voice of service users, their carers and the public? I have spent many years developing and managing service user and community engagement programmes at local, regional and national level that have produced significant change for services and commissioning.

Last week we saw the publication of the guidance on authorisation for clinical commissioning groups which includes:

"Meaningful engagement with patients, carers and their communities".

So far so good, but meaningful engagement takes time, expertise, understanding and above all the willingness to act on what people say. It is not a cheap option. The guidance goes on to state that:

"Plans are in place to ensure that the emerging CCGs can effectively engage with and gather insight from patients and the public, including disadvantaged groups".

Perhaps the noble Earl can tell us what these plans consist of? Three questions spring to mind. How is this to be accomplished? What resources are the Government providing to make this happen and, most importantly, where is the expertise? While I agree that those who use services should be at the forefront of driving up standards of care, there must also be adequate safeguards of independent monitoring and inspection. I am concerned that the Bill threatens to weaken such safeguards.

At the end of my tenure as chair of the Mental Health Act Commission, I was responsible for seeing it merge into what is now the Care Quality Commission. I continue to watch the CQC closely. The merger was designed to simplify the regulatory landscape, but the Bill seems to create yet more complication. Under the Bill, Monitor and the Care Quality Commission have oversight over service providers, but responsibility for overseeing commissioning will lie with the newly created NHS Commissioning Board. So we are back to having different bodies monitoring different aspects of health and social care.

In the case of the CQC, the Bill further reduces its independence: Clause 287 requires the Secretary of State's permission for the CQC to conduct special reviews. The *Health Service Journal* reported, on 6 October, that according to the CQC's own internal review, doubts have been expressed that it can sustain its current workload.

The CQC has a third less funding than those bodies it replaced and has had to cut generic inspections by around 70 per cent last year because of pressures in registering services. It is currently being asked to cover 18,000 care homes and 400 NHS trusts and will now be asked to take on responsibility for GP practices and the yet-to-be-determined number of "any qualified providers" who may be pressing for registration, all of which will once again distract the CQC from its vital inspection role.

I am pleased to see that, so far, the CQC has not reduced its visits to detained patients. It must be congratulated on that, but I question how that can be sustained, given the immense additional pressures to be produced under the current proposals in the Bill. I would like to be assured, if the Minister can, that the gains envisaged in the merger of the Mental Health Act Commission, the Healthcare Commission and the Commission for Social Care Inspection will be realised. We do not want any more horrors like Winterbourne View in mental health services. I hope that noble Lords will recognise the immense amount of work that is still to be done, and that the Government will concede that we must take the appropriate time to do that. Failure to take that time will risk lasting and, most importantly, irreversible damage to one of our greatest post-war achievements: a National Health Service that works in the interests of patients and the public, not in the interests of ideology.

3.15 pm

Lord Low of Dalston: My Lords, this Bill would entrench—for it has already begun—the most radical reorganisation of the National Health Service since it was founded over 60 years ago.

I share all the concerns which the experts have articulated as flowing from the marketisation of healthcare along American lines: that is to say, in the direction of a system that is twice as expensive and much less efficient than ours. There is the impossibility of rational planning, the fragmentation of purchasing and procurement arrangements among hundreds of different entities, with the consequent loss of economies of scale. There is the embedding of incentives to physician-induced and supplier-induced demand—which the noble Baroness, Lady Williams, illustrated so graphically—leading to unnecessary tests, treatments, the diagnosis of minor problems as major, and over-aggressive treatments that might actually harm the patients subjected to them, all undertaken to increase provider income. That is not to mention the proliferation of bureaucracy required to administer the byzantine commissioning and contracting process.

The noble Lord, Lord Hennessy, said on the radio this morning that the NHS was about the nearest thing we had to the institutionalisation of altruism. The Bill, laden as it is with incentives for opportunistic behaviour, drives in entirely the opposite direction and bids fair to dismantle that system.

As Dr Lucy Reynolds and Professor Martin McKee have said, the ethics of the medical profession may provide a safeguard against patient exploitation, but unnecessarily putting temptation in doctors' way is surely unwise. How much more is that the case—as the noble Baroness, Lady Bakewell, demonstrated earlier to such devastating effect—with healthcare providers whose sole objective is to turn a profit, with all the dangers that that presents of asset-stripping and cherry-picking among the low hanging fruit, in the clearest illustration of the conflict between commercial and social values, of which the noble Baroness, Lady Jay, spoke earlier, echoing the words of Aneurin Bevan?

There is already the risk of destabilisation as a result of the Government's determination to charge ahead. If ever there was a case of implementation before legislation, with consultation coming a poor third, this is it. Only this weekend, someone wrote to me saying:

"Some of our close friends are now experiencing not only lengthening waiting lists but inefficient follow-up procedure appointments as the cuts deepen and changes are already being made in many areas of the health service".

There is little I can add in this vein to what those better versed in these matters have said. Instead, I will concretely illustrate the problems to which the legislation gives rise by reference to the field of eye health. Your Lordships would not expect me to speak without alluding to eye health. While declaring my interest as a vice-president of the RNIB, I have no compunction in doing so because it provides such a good illustration of many of the concerns held by critics of the legislation.

There are four particular concerns about eye health services that I would like to put to the Minister. The first is that of fragmentation. We currently have eye departments across England and Wales that provide a generally high level of care. They offer a comprehensive range of treatments for the main eye conditions, including cataracts, age-related macular degeneration, diabetic eye disease and glaucoma. However, with any qualified provider, this is likely to be quickly eroded with the disappearance of, for example, straightforward cataract surgery to private providers. Although that may be presented as a contribution to the QIPP agenda, it will have many unintended and damaging consequences.

Who, for example, will deal with the more complex operations and the inevitable complications? How do eye departments put together full and efficient operating lists? How can a smaller and fragmented eye department provide effective training for the next generation of ophthalmologists? How is an effective and comprehensive eye emergency service to be delivered?

A second concern relates to the failure so far to place eye health at the centre of the Government's public health agenda. With an ageing population, visual impairment and blindness are now a bigger public health challenge to quality of life and cost—estimated at £22 billion in 2008—than the major killer diseases. It is all the more galling that 50 per cent of this is estimated to be preventable through early diagnosis and intervention.

The UK Vision Strategy, a coalition of all the major players in the vision impairment sector—the Royal College of Ophthalmologists, the Optical Confederation and the RNIB—has been arguing strongly for an ophthalmic public health indicator for avoiding blindness in the national framework. This would provide focus for clinical commissioning groups, health and well-being boards and Public Health England in this important area. However, it is increasingly concerned that such an indicator will not be included in the final framework when it is published later this year. That would be a major opportunity missed.

My third concern is about integrated planning and delivery across health, social care and health-related services. The establishment of local health and well-being boards to promote co-ordinated planning is to be welcomed. It is here that commissioners of health, social care and public health services will come together to develop the local joint health and well-being strategies adumbrated in Clauses 190 and 191. However, whether this can be an efficient and effective process with two to three times as many commissioning groups as at present—300 to 450 clinical commissioning groups in future, compared with 152 PCTs—must be in doubt.

My fourth concern relates to the role of NICE within the new framework. In their response to the NHS Future Forum, the Government confirmed that the funding direction requiring NHS commissioners to fund drugs and treatments in line with NICE's recommendations would still apply until at least 2014, when value-based pricing will be introduced. However, enforcing the funding direction is already proving difficult—for example, in relation to anti-VEGF treatments used for the treatment of wet age-related macular degeneration. What reassurances can the Government offer patients that, from 2014, value-based pricing will not restrict access to innovative treatments? How will the funding direction be enforced in the event that a clinical commissioning group chooses to exercise local autonomy—for instance, where it faces serious cost pressures? It would be very helpful to have this clarified so that patients who develop eye problems and other health conditions can have confidence that drugs or treatments recommended by NICE will still be available to them.

3.23 pm

Baroness Wall of New Barnet: My Lords, it was my intention to focus in my contribution on healthcare assistants and their regulation. I focused on that issue because of its importance in patient care. However, I have an opportunity to raise that in the Question that I have tabled for 24 October and I give due notice to the Minister that I will be doing so.

I have listened carefully to almost every contribution, and the three or four for which I was not in the Chamber I listened to in my office. Many of these contributions have come from eminent and experienced noble Lords, all of whom present very plausible arguments for their particular suggested outcome of how the House deals with this important and complex Bill. In relative terms I am quite new to this House and certainly would not describe myself as an eminent Member, but I am the chairman of a two-hospital provider trust. I know that most noble Lords who have an interest in health and have participated in debates on it in this House will know that only too well, and they are probably weary of me mentioning my trust, Barnet and Chase Farm—but I shall resist doing so today. I am a champion and advocate not only for my trust but for the principles behind the formation and continuation of the NHS. However, as noble Lords have said, the NHS that we are dealing with today is very different. The expectations placed on it—from patients, clinicians and all professional staff and support workers—are different. Those employed in this service are caring for patients. As someone who takes her role very seriously, I find that challenging but also very exciting.

We have heard today about advances of technology in medicine and many other areas which have improved the lives of thousands of patients. This is happening increasingly and it is wonderful. However, it also brings challenges of affordability and the necessity to ensure that we have the most skilled and caring workforce. These are real challenges which mean that we cannot stay as we are.

I have been in my role as a chair for five years, and in that time I have been delighted by many of the changes and improvements that my party introduced during its time in government. Most people who serve our patients have valued those extensions and improvements to the service. When the coalition Government were formed, I was keen for many of these initiatives to be carried on and improved. Many have indeed been carried on, and it is proposed that they should move even further. This will benefit patients.

The only barometer I need to test the benefits of the Bill is whether it makes a difference to patients. Like others, I have had the opportunity to speak to the Minister about my anxieties and expectations over the way forward, and like others, I was treated with warmth and politeness. However, we need action now. I have received lots of correspondence, as have most other noble Lords, from all kinds of organisations and individuals. I am not sure whether I am unique, but I was privileged to have discussions with groups of staff and patients from my hospital when I advised them that I intended to speak in this debate. They asked for a meeting and I was delighted to provide it. They told me that they had some worries about parts of the Bill. They were not sure what the new structures that they were required to work in meant but thought that they looked complicated. They said that they had just got used to the reorganisation of commissioners, which seems to be working well. What does this mean in the new regime that is proposed by the Bill?

More than anything, what they want from the Government is clarity about the importance of patient experience and the emphasis on whether patients should come into hospital or be treated in the community. That emphasis is not as good and deep in the Bill as it should be. I am sure that the Government are concerned about patients' experience. I urge all of us to use the time that we have not only to persuade the noble Earl, Lord Howe, that we believe that he cares and wants better healthcare, but to listen further to suggestions to improve the Bill. What everybody said to me was, "Please, Baroness Wall, whatever you do, don't kick this into the long grass". We do not need to do that, and I have no intention of voting to do so.

3.28 pm

Baroness Masham of Ilton: My Lords, we have before us a monster of a Bill. It is complex and confusing. Many people who depend on the NHS are concerned about what the results will be when it becomes law. There are improvements that should be made to the NHS but it will be a tragedy if good and excellent things are lost or downgraded.

Safety of all patients is my top priority. We do not have enough high-dependency beds. We are well down the European list, which is headed by Germany and France. We have many critically ill patients. There is a gulf between intensive care and the general wards. There is a dark cloud hanging over England, which must save £20 billion when the NHS has increasing lists of patients who need treatment and medication. With commissioning being done by clinicians who might have self-interests, perhaps I may ask the Minister if there are enough safeguards in the Bill. If patients become suspicious of their doctors and trust is lost, that will be a tragic disaster. There should be integrated healthcare, and patient and public involvement to help with commissioning. Many members of the public who have paid their taxes and national insurance feel that the National Health Service is there for them when they need it.

Many people, including professionals, think that healthcare assistants working in hospitals and care homes are registered. They are surprised when they hear that they are not. Many members of the public were horrified and dismayed when they learnt about the callousness and cruelty to patients over a long period at the Mid-Staffordshire NHS Foundation Trust, when the system within the hospital let them down; and likewise when they saw the "Panorama" programme about the care home, Winterbourne View. This sort of behaviour to patients just cannot go on.

It is welcome that the Government have recognised that unregulated workers supporting healthcare professionals represent a risk to patient safety that needs to be addressed through regulation. I strongly believe that only a mandatory regulatory model will be sufficiently robust to safeguard these workers who

present the greatest risk to patient safety and public well-being. I believe that Clauses 225 and 226 of the Bill should be made mandatory.

Care assistants are often dressed up in uniforms that make them indistinguishable from nurses. When the national nursing research unit at King's College, London carried out a review of models of regulation of support workers, it found that for the two types of healthcare support workers—healthcare assistants and assistant practitioners—there are no consistent UK-wide training standards. Healthcare assistant courses can range from an hour-long induction to NVQ level 3. Assistant practitioners undertake more complex tasks than healthcare assistants, but again there is no training consistency across the UK. The report demonstrates that both often undertake tasks for which they are not trained. The lack of regulation means that employment as a support worker may be obtained by people who have been dismissed from a previous healthcare post for misconduct, or who have been struck off the register as a nurse or a midwife. I will be moving or supporting amendments to try to help rectify this unsatisfactory situation.

I am sure that nobody would disagree with the importance of the patient voice in the reforms—no decision about me without me. Can the Minister, the noble Earl, Lord Howe, who is so hard-working and committed to high-quality health care, assure me that specialist care for patients who need it will not be affected during this period of upheaval in the NHS? The cuts are already causing concerns in various directions. Some of the expert advisers within the Department of Health have retired and have not been replaced. One is the microbiologist who advises on infection control. With the increase of drug resistance to various infections such as E. coli and tuberculosis, perhaps I may ask a question. There are many specialties of illness, disease and infection. Will the commissioners have advisers so that they will understand what they are commissioning? I hope that the Minister will have a positive answer.

With the increase in HIV/AIDS and other sexually transmitted diseases, what will the Government do to ensure that stigmatising views of HIV and of sexual health more broadly do not affect decisions about local public health services? Can the Government confirm how the NHS Commissioning Board will be held to account for the quality of its own commissioning, and by whom? I ask this in particular in relation to HIV treatment and care, and healthcare in prisons and other places of detention. Will the Government allow for a national tariff covering sexual health services to be applied to local authorities as part of the mandate for Public Health England? Will the Government specifically allow the pre-existing tariff for GUM and sexual reproductive health to be used? There is fear that the service might become fragmented.

How is the patient voice to be heard? It is important for special groups such as Diabetes UK, and patients' groups such as the Spinal Injuries Association, the Patients Association and hundreds more, to speak out and be heard. The Government are setting up HealthWatch. It would have been helpful if Governments had built on community health councils, but this was not to be. Health forums were set up and then closed down. Then came LINks, which few people have heard of and are not well supported. It is felt that HealthWatch should be independent of local authorities and the CQC if it is to be an effective body representing the public's interest in the NHS and social care. HealthWatch England must be an accountable and democratic body, and some of its members should be elected from local HealthWatch bodies. Local HealthWatch must be seen by patients and the public—and particularly by users of social care services—as being independent and serving their needs. If local HealthWatch is made accountable to its local authority the public will have no confidence that it will stand up for and represent them when things go wrong.

The lessons should be learnt from Mid Staffordshire NHS Foundation Trust and the numerous care homes that have become places of oppression and agony for the residents. HealthWatch cannot be both champion of the public and poodle of the local authority. It is essential that primary and secondary health work is done in co-operation, and that pharmacists are involved. They are concerned that currently in the legislation provision for clinical commissioning groups to obtain appropriate advice is too vague. I hope that your Lordships will be able to do what the House of Lords is good at, which is to improve this mammoth Bill for the good of the NHS and of those who serve in it and who use it.

3.38 pm

Baroness Cumberlege: My Lords, I declare an interest as executive director of Cumberlege Connections, which is a training organisation. I am also a fellow of three royal colleges and have associations with a number of health charities.

"The GPs of the future …working closely with social services, should have a wonderful chance to organise the complete care of the community".

Those are not my words but those of a great leader of the medical profession—the remarkable Archie Cochrane, when he gave the Rock Carling lecture at the Nuffield Trust in 1971, 40 years ago. Forty years ago he could see the sense in putting GPs in the driving seat. But I know that there are many GPs who would be back-seat drivers rather than take on the,

"wonderful chance to organise the complete care of the community".

I can really understand why. It is a great responsibility. It takes courage. It is very demanding and many of them feel that it is not their vocation. They came into medicine to treat, cure and heal. Fair enough. But we are not asking every GP to step up to the plate—only those who want or feel able to.

After the report on medical professionalism commissioned by the Royal College of Physicians was published, I was invited to a number of roadshows across the UK, sponsored by the King's Fund, to explain the thinking of the working party I had chaired. On one such occasion in Bristol the hall was full and we invited feedback from the audience. A very distinguished and respected hospital consultant said: "I remember the Griffiths reforms in the 1980s. Roy Griffiths recommended the introduction of general management and we the medical profession said, Right, you can have your managers, they can manage, but we will go away and stick to our clinical work. What fools we were!".

[Baroness Cumberlege]

We are now giving clinicians another chance—not to be day-to-day managers, not to become expert finance directors poring over endless spreadsheets, but to lead, shape and organise the services that they know matter to patients. That makes a lot of sense. We know that 95 per cent of healthcare problems are dealt with by GPs and their practice teams; more than 15 per cent of the entire population see a GP in any two-week period; and 75 per cent of patients want to consult a GP they know and trust. It seems sensible that those who are so trusted by their service users should be designing services and commissioning them. Currently the PCTs do that.

Since the threat of abolition there has been a great wave of nostalgia for the good old PCTs. Never before have they been so loved and wanted. I recently spent two days in Torbay and if only all PCTs were as good as Torbay the case for change would be hard to make. But sadly that is not the situation. Too many PCTs have been criticised for their inefficiency, lack of understanding of clinical issues and inability to commission quality across the board.

Dr Clare Gerada, the chair of the Royal College of GPs, writing in her blog last month said:

"We should be taking every opportunity to celebrate the health service … That's not being complacent, and the College has long argued that there is room for reform".

I so agree. She went on to say:

"One thing I am confident of is that we will not see a full adoption of the market-driven health service provided in the US and for that I think we should be relieved".

Me, too, my Lords. I do not want the NHS to be driven by a credit card economy—I want it to offer the best.

People move house in order to get the education they think best for their children. Parents know all about "pester power"—from a very young age children are deeply competitive. They want the very best: the best trainers, the best scooter, the best track suit. It is part of human nature—we are competitive animals. For those of us who know the NHS well, we will choose the best: the best hospital, the best GP, the best clinic for ourselves and our families. For me, raising standards means removing the worst and installing the best. If people want to call that competition—fine. I call it something to strive for.

If Assura Medical is judged, after a fair and open process, to run, manage and deliver a better service of higher quality than the NHS, I cannot understand why the noble Baroness, Lady Jay, should be so concerned, particularly when we know that the Brunswick research shows that patients are not especially worried about who provides the service, so long as it is of a very high standard and free at the point of use.

According to the CQC, 96 per cent of NHS patients using independent facilities for elective surgery are satisfied, but only 79 per cent of those using NHS facilities. Commenting on the seminal four-year study by the University of York into competition in the NHS, Julian Le Grand, professor of social policy at the LSE and policy adviser to the then Prime Minister, Tony Blair, told the *Financial Times* yesterday:

"This is a very important result. It shows that one of the most frequent criticisms of patient choice and hospital competition in the NHS—that it would disadvantage the less well-off—is quite misplaced".

The NHS is of itself competitive. When dealing with the pharmaceutical industry, it negotiates for the best deals, moving to generic medicines when it is to its advantage. And yet here we have people within the NHS who are being highly protective when it comes to service provision. They will resist any suggestion that another organisation outside of the NHS should provide a service, even if it is of a higher quality, more efficient, innovative, and giving the taxpayer better value for money. This is simply inconsistent.

The basis of democracy is competition. There is competition for seats in another place, and competition for party leaderships is so fierce that brother competes against brother. The best win, losers are driven out. Why are these principles attacked by the vested interests within the NHS? Is it to hide bad practice from scrutiny? Is it barefaced protection of inefficiency and the worst manifestation of trade unionism? We, the people, demand open government. The NHS should not demand a closed shop—a cosy nest on a rotten bough.

I accept that this Bill is not universally loved, but it does bring the NHS into the real world. There is room for scrutiny and improvement, which as always your Lordships in Committee will undertake with wisdom, skill and, in this case, fortitude. I will be voting against the amendments proposed by the two noble Lords in this debate for the cogent reasons outlined by my noble friend Lord Howe.

3.48 pm

Lord Clinton-Davis: With apologies to Leviticus, may I say that this debate has been a time when many invaluable ideas have been put forward, and when one has learnt so much; and this process will continue. But at the end of the day—or rather tomorrow—I will unhesitatingly vote against this destructive Bill and support both amendments, if need be.

The National Health Service, established more than 60 years ago, proved to be one of the most enduring of many enduring accomplishments of the 1945 Labour Government. It is cherished by most of our population and envied by many outside Britain. Even the present Government pay lip service to it.

Our people are overwhelmingly opposed to the dismemberment of their National Health Service. From its beginnings, the Tories tried to wreck it, with no apology and no admission that they were wrong then, as they are now. Just seven years ago, a Tory spokesman, Oliver Letwin, let the cat out of the bag. He declared that the National Health Service would disappear within five years of the Tories coming to power. Is this not what this Bill means in the long term?

I do not contend that the NHS is without flaws. These were recognised by the previous Government. But the essential remedies, it seems, have been sidelined. Instead, this Government are allowing our comprehensive health service to wither on the vine. What I argue is that the NHS, despite the strains placed upon it by immense technical advance, is better—far better—than anything which might be put into its place.

Private health companies continue to pour huge sums of money into Conservative coffers. Why? What do they hope to get out of it? When the Prime Minister and others claim that these so-called reforms are designed to improve the health service, they are disbelieved by senior doctors and others employed in and dedicated to the NHS. For "improve" they should substitute "fragment".

The Government talk of widespread consultation about their programme but in fact turn a deaf ear to any serious criticisms of their plans and potential deleterious effects on patients. Consultants and others remain unconvinced by the Government's proposals to allow the private sector to work within the National Health Service. They consider that costs will spiral, and the founding principle of the NHS, which has served millions of people so well for so many years, will be irrevocably damaged.

The House of Commons, to its shame, has endorsed this Bill. The Lib Dems—with four honourable exceptions—have reneged on their previous commitments. What will they do tomorrow? Will they follow the example of the noble Baroness, Lady Williams? I do not know.

I was somewhat surprised that, when addressing the Independent Healthcare Forum, the noble Earl, Lord Howe—for whom personally I have enormous respect—declared that the private sector would be presented with "huge opportunities". Opportunities for what? For whom? At whose expense?

I do not think that the NHS is safe in the hands of this Government. What they proclaimed not so long ago, in contrast to what they propose today, bears out these suspicions and, indeed, concerns.

While the coalition tinkers with its so-called reforms, the reality is that the NHS will be removed from its original concept—and that is something which my party will, I hope, strenuously resist.

3.54 pm

Lord Rodgers of Quarry Bank: My Lords, on the occasion of a debate in the House on 16 December last, I said that I had been agnostic about the merits of the July 2010 *Liberating the NHS* White Paper and nor had I been persuaded since. Ten months later, I have moved on, but I am still uneasy about the Bill. That is the way I shall remain, long after the legislation is passed and when the policy is finally implemented. Only time will show fully the outcome of the Bill and the balance of advantage. There will certainly be rough edges and mistakes, and lessons will have to be learnt. The NHS is an immensely complex and living institution and we cannot know the extent of change for the better.

There have been legitimate and strong differences about the health service ever since it was established in 1948. Two years later, NHS costs and the decisions to charge for teeth and spectacles divided the Attlee Cabinet and damaged the Government. Wide differences on this Bill will remain, including over the role and extent of the private market within the public sector. I am impressed that the country has already been covered by the shadow clinical commissioning groups. There are now 250 of them. Some are small groupings but others—like the London Borough of Camden, Oxfordshire and now Sheffield—are large and, in effect, conglomerates. A lot of GPs are enthusiastic and well informed, despite the unbending criticism of the Bill by the chairman of the council of the Royal College of General Practitioners.

However, the picture is patchy and there are also dissident and unhappy GPs. They say that they are clinical experts and do not wish to become experienced commissioners, and are not interested and competent in administration. It is not clear what happens when a shadow CCG fails to meet the statutory requirement. On the face of it, the Secretary of State wants CCGs to get on with it but it could end in a confused picture by 2013.

In the July White Paper, it was said that the new Commissioning Board would be a "lean and expert organisation". Sir David's board may be expert but it will certainly not be lean. I make no complaint, as it seems to me that Sir David will have to take a grip on problems arising from failures by the CCGs. There could be tension between letting go and retaining control at the board, and we should be aware of the limits of localism.

In the debate of 16 December, I referred to the ending of the primary care trusts. I drew attention to a success story in PCTs reaching agreement about having fewer and more sophisticated stroke units in London hospitals. In contrast, there had been an all-party outcry against the possibility of closing the A&E departments in the Whittington Hospital—near to my home—and elsewhere. The closure of Chase Farm A&E has recently made news and is an object lesson of short-term politics and pointless delay. The role of CCGs in respect of closures, and whether they will have a constructive role in those decisions, is far from clear.

The chief executive of the NHS Confederation reminded us that the health service is facing £20 billion of efficiency savings by 2015—a huge sum in a very short time. Moving services and closing complete hospitals may be essential while raising standards for the benefit of the patients. It could be said that these priorities and tasks in saving the NHS should have been treated ahead of the Bill. There is deep concern about whether the NHS can deliver greater efficiency and quality while overhauling the NHS structures in the Bill.

In successive Governments since Gladstone, the Treasury has thrown up its hands in horror at the possibility of hypothecated taxation in a major area of policy. However, it may now be right to consider hypothecated taxation for the NHS. This would make NHS expenditure more transparent, showing the public—the taxpayer—the awkward choices when the demand for services is at above the rate of inflation due to rising expectations, an ageing population and increased technological costs.

Meanwhile, we have the Second Reading today and tomorrow in the knowledge of much still to be done in scrutinising the Bill in the hope of agreed amendments that will lead to further improvements and relieve some of the anxieties. However, I cannot support the amendments in the names of the noble Lords, Lord Rea and Lord Owen. Since the publication of the July 2010 White Paper, there has been a deluge of consultation papers and memoranda. Following the White Paper,

[Lord Rodgers of Quarry Bank]
the Secretary of State published a sheaf of separate documents covering every aspect of his proposals and invited a response. In due course, every medical professional body expressed their views and the trade unions and many lobbyists on behalf of good medical causes began a steady and lengthy campaign. This was entirely appropriate, as it exposed in detail the importance of these distinct issues.

In due course, the Bill was published and reached the Commons for Second Reading. Again, there was another flood of paper prior to the beginning of parliamentary scrutiny. At the same time, my noble friend Lady Williams of Crosby took up the cudgels on key controversial aspects of the Bill and the Liberal Democrats made the running for amendments. After that, the NHS Future Forum, led by Professor Field, was devised and during what was called a "pause", there was a further set of documents independent of the Secretary of State and the department.

I will not tell the story of the White Paper and the Bill any further, as noble Lords are very familiar with the whole saga. However, I will mention the report of the Constitution Committee. As the noble Baroness, Lady Jay—the chairman of the committee—said this morning, the committee has expressed its concern that the Bill might dilute the Government's constitutional responsibilities with regard to the NHS. Despite today's disappointing government response, I hope Ministers will think again.

By lunchtime tomorrow, there will have been over 90 speeches advocating many shades of opinion. I am a lay man in a debate dominated by medical experts. I have heard speeches critical of the Bill and others as uneasy as I personally remain. However, I find no advantage in another Select Committee. We shall give thorough scrutiny to the Bill in Committee and on Report; it will be the end of a long, perhaps unique, process of argument and examination. The House is now able to make fully informed decisions. Whether we like them or not, we should not duck or delay them further.

4.03 pm

Baroness Murphy: My Lords, we are not alone. All over the world, advanced healthcare systems are trying to tackle the quality of care and safety, raise productivity and shift the care from acute hospitals into primary and community settings—whether it is surgical, medical or mental health services. We have well rehearsed today the reasons for that and the imperative of finding a sustainable way forward for the 21st century that meets the aspirations of Bevan and the founders of the NHS. This is a most remarkable institution, but we need to improve on it to meet what patients need and want now and over these next challenging years. I support this Bill as a well reasoned way forward and as a sensible step which builds on the international and local evidence.

It is time for me to declare my interests as a lifelong employee and honorary employee as a doctor, clinical academic and NHS manager. I am proud to say to the noble Baroness, Lady Cumberlege, that I was one of the original Roy Griffiths managers. If you like, I got on that horse quite early. I then chaired a university with a medical school, St George's, and finally, recently I was on the board of Monitor, the NHS foundation trust regulator.

Seldom have so many health policy folk fought so many pre-Bill skirmishes over what in the end has proved to be rather modest changes intended to preserve and improve the NHS based on the principles of the NHS constitution, and rarely have I received so much misinformed lobbying about a Bill. I hear that the Bill heralds the end of the NHS as we know it; I read that armies of evil capitalists from the United States and the Middle East are geared up to zoom into the UK like the hordes of Genghis Khan to hoover up our favourite hospitals and services. It is twaddle. In fact, this Bill contains no privatisation at all, it does not transfer any assets to the independent sector and, if we build on the contribution of the independent sector of 1 to 2 per cent per annum, we shall be doing quite well. We have been building on the expansion of existing policies that have been in place and developing slowly over the past 20 years and introducing a new level playing field for providers from all sectors.

As another noble Lord said, this is a vast improvement on favouring the independent sector treatment centres. I quite understand why that had to be done in the early days, but this puts everybody on a favourable, equal footing. It will sharpen NHS commissioners to get the quality of care improved and, crucially, will improve productivity, which has fallen quite catastrophically as investment has risen in the past decade. This Bill improves the contribution of clinicians to the planning and management of services and shifts a hospital system chained to central diktat towards a regulated emancipation to manage their own affairs. In my view, the most important aspect of this Bill is the introduction of the independent regulatory framework for providers, with the tools to promote a sharpening of competition and co-operation that will promote the kind of integrated care across primary community and specialist services that we all want.

Those of us who were at the meeting last night heard Sir David Nicholson repeat what the NHS Confederation has constantly stressed: that any delay will be profoundly depressing to the service, which now wants a clear steer and direction of travel. We have had two years of delay already. Almost all the features of this Bill are familiar to us: clinical commissioning; foundation trusts; a regulatory system; competition and collaboration between qualified providers; and patient choice. They have all gone before, so the new Bill builds on what has been learnt, especially by ensuring that competition is based on quality not price. There seems to be a widespread misunderstanding that we are basing these new proposals around price. That is absolutely not the case, and I would not support this Bill if it did.

Some people talk nostalgically about the demise of PCTs and SHAs, but the demise is in an orderly fashion, and as a former chair of a strategic health authority, I can only say "Hurrah". In fact, clinical commissioning groups are what primary care trusts were supposed to be in the first place. For those who can recall primary care groups, those were also what clinical commissioning groups were meant to be. The

difference is that we have a national framework to support and empower them that will not be diverted into the provider system. Sir David Nicholson has articulated a wide range of commissioning support arrangements that he intends to implement, and we need a Bill to bring those changes about. I have heard it widely said that they will somehow come about if we all think hard enough and that we do not need a Bill. That is rubbish; we need a proper legislative framework. I shall come on to the constitutional changes that people suspect may be in the air—they are not—but we need responsibilities to be articulated very clearly in legislation.

I cannot be the only person who thinks that it was a stroke of genius to appoint Sir David Nicholson as the new CEO of the Commissioning Board, because that will ensure that the transition arrangements are far less worrying for the service. We should be very relieved that he is there to support the new clinical commissioning edifice, including the regional offices and the different ways of commissioning at different levels to support the cancer and stroke care networks—all the precious things that we want to hang on to.

Many people have mentioned the change of wording relating to the Secretary of State's responsibilities. That is not, by the way, something that is ever raised in the service, where there do not seem to be any doubts that the Secretary of State will still be very much in charge. I worked out that the Secretary of State last managed services directly in 1989, when the special hospital services transferred out of the Department of Health into the new Special Hospitals Service Authority. I do not think that there have been any directly managed healthcare services since then; they have been provided through agencies. Therefore, the description of what the Secretary of State does has been poorly worded. We now need an accurate description of what we think he is going to do. He will not lose political accountability, and he will have specific responsibilities for the health of the public. Is that not what we want the Secretary of State to have? I am sure that we can find some wording to reflect what he will really be doing—it may not be quite right in the Bill. I read the Constitution Committee's report with much interest. It is fascinating. If we are to debate it, let us do so on the Floor of the House—we have constitutional experts in this House who are a delight to listen to—and see whether we can get this matter right with amendment, explanation or whatever.

Public health started with local authorities and it is returning home. The Secretary of State has very clear responsibilities, and I think that Public Health England, which will provide the support to public health specialists in the localities, is probably as good a solution as we have had since 1974. Therefore, again, I support that.

The development of Monitor to become the main economic regulator is also welcome. Safeguards put in place following the listening exercises are now very extensive—some might say too constraining. Monitor is to have regard to a whole list of things and I wonder whether we might be able to moderate that slightly. Other regulators have shown that there are too many responsibilities at the moment, and we need to find a way forward. However, I particularly welcome the way in which the tariffs are being developed, with new ways to innovate on the design of services, and the way that the tariffs can be bundled to provide the better vertical integration of services that we want to see.

There has been much angst in some quarters about the abolition of the private patients cap. I understand why and I am very sympathetic to the unions' concerns. No one wants to divert NHS clinicians' and managers' energies and preoccupations into private care, however much cash it brings in. However, the cap has proved to be technically extraordinarily difficult to get right, highly disadvantageous to mental health services and a real barrier to some of our great teaching hospitals becoming foundation trusts because some patients are recruited from abroad—Great Ormond Street is a good example. We have to think very carefully about how we go forward in discussions on that.

Finally, I have one major concern. How are we ever to get services reconfigured or units and hospitals closed? Mid Staffs was not an outlier very far from other hospitals. Perhaps a quarter or so of our DGHs are redundant, and many more services need concentrating on specialist sites if we are to improve quality. I want to ensure that Monitor has the tools to intervene early and the right processes to complete the changes. It is always politically difficult to make the final decisions and most inaction on failed organisations—we have already had quoted the wonderful Chase Farm—is caused by lack of ministerial bottle. In Ontario, the ultimate decision was moved from ministers to an independent organisation and finally people started to get the movement that they needed. We have left the Secretary of State in the same old role, so when people are thinking about constitutional changes, they need to remember that. The failure regime has become exceptionally difficult. Can the Minister reassure me that the system can be made to work and, if it proves impossible, that Ministers will have another strategy up their sleeves?

Just as education Bills do not improve education without improving teachers, so we will not improve healthcare without improving the quality of doctors, nurses, other professionals and the people who deliver care, including the managers. We do not talk enough about that, but for the moment I will support the Bill and will not support the amendments that have been tabled to it.

4.16 pm

Lord Warner: My Lords, it is always a pleasure to follow the noble Baroness, Lady Murphy. I detect from her remarks that I may have been forgiven for her old SHA being one of the 18 that I abolished five years ago.

As you walk into Parliament from the Underground, you see a large poster telling the citizenry that they can find out how laws are passed here. Let us hope that this Bill is not used as a case study. The Government's approach has done few favours to the cause of NHS reform, which many of us believe is still needed. The failure to produce a convincing narrative on why change is required on this scale has allowed the utterly predictable voices of reaction and vested interests to drive the agenda of opposition. They have made things worse by failing to show how their legislation will help the

[Lord Warner]
NHS to tackle the financial, demographic and public expectation challenges that it faces, particularly the £20 billion efficiency gain required over the next four years.

A key plank of Andrew Lansley's defence has been that he was just continuing the Blair health reforms. That has a slug of truth in it, but he fails to acknowledge that those of us implementing those reforms had a clear mandate to do so in our 2005 manifesto, with which, I say to my colleagues, we won an election.

It is very easy with this Bill and the Government's handling to engage in political point-scoring. However, I suggest that our greater responsibility in this House should be to the current needs of the NHS and how we can best make this Bill more fit for purpose. NHS staff are in a no-man's land between a partially dismantled system and no clear and workable new system in place to which they can transition. This is a bad place to be, given the state of the public finances and the challenges that the NHS faces. Now, the NHS needs the maximum removal of uncertainty and the strategic leadership to take it forward confidently, as so eloquently advocated by my noble friend Lord Darzi. All that scrapping the Bill would do is worsen the chaos. The grown-up thing to do is to improve the Bill as quickly as possible so that the NHS can move forward with greater certainty. From my own inquiries, that is the view of the NHS Confederation, which has provided us all with an excellent briefing.

Of course, this House needs to discharge its functions of scrutinising the Bill, and it needs to do that thoroughly, speedily and with a clear sense of purpose. The guiding principle should be fashioning amendments that make the NHS more likely to be able to deal with the challenges that it faces over the coming years. That will certainly be my approach, drawing on expert help both inside and outside this House.

Neither of the amendments to the Motion of the noble Earl, Lord Howe, helps in this regard. My noble friend's Motion is well intentioned but thoroughly misguided, given the needs of today's NHS, and I cannot support it. Nor will I support the amendment of the noble Lord, Lord Owen.

We should recognise that we have enough evidence of the Bill's strengths and shortcomings, as the noble Lord, Lord Rodgers of Quarry Bank, pointed out to us. We have now to settle down in a Committee of the whole House and work our way through the amendments to improve the Bill. In this regard, I hope we will find the Minister in a listening and negotiating mood. Perhaps he will recall that when I took another rather controversial health Bill through this House, on foundation trusts in 2003, I moved or accepted some 200 amendments. So that is the benchmark for judging the flexibility of the noble Earl opposite.

I shall comment briefly on the Constitution Committee's report. The Secretary of State's responsibility for health service provision has always been a bit of a fiction when it comes to accountability. Clause 1 seems to me a more accurate description of where the Secretary of State's responsibility and accountability are now and where they should remain, although I shall certainly argue in Committee that his powers of mandation in the Bill are rather too unconstrained. I found the Minister's response to the Constitution Committee convincing and cannot see much point spending too much further time on this issue.

I make it clear that I am proud of Labour's improvements to the NHS and the external recognition of them. We have better buildings and equipment, including IT, much needed extra staff, better service access and a huge improvement in the clinical performance on the killer diseases: cancer, coronary heart disease and stroke. But NHS productivity was poor relative to the scale of that investment. Office for National Statistics figures show inputs growing by 60 per cent in real terms between 1997 and 2007 and output barely moving. That is not a good performance. A major programme of service reconfiguration is required quickly. Too many acute hospitals are not good enough for FT status now, let alone in the tougher climate ahead, and the 1960s all-purpose district general hospital is an out-of-date, failing business model. We need change in configuration. We need to give great attention to the part of the Bill that deals with it and to strengthen the ability of decisions to be taken locally, clinically and without too much political interference. We have talked the talk on integration, but the Bill needs to walk the walk, especially on integrating health and social care. We need to remember that social care is in the Bill's title. NHS performance requirements need strengthening so that the public have access to much more useful information. We need to clarify, and simplify, the extremely complex set of arrangements in the Bill for fixing the NHS tariff.

These areas and others such as public health, the patient's voice, social care reform, research, NICE and the NHS Information Centre all need attention, but those are things that we can deal with in Committee.

Perhaps I may say a few words about the vexed question of competition, which is not privatisation, is integrally linked with extending patient choice and is not incompatible with service integration. I end with a quotation from a recent study that was peer-reviewed and appeared in the *Economic Journal*. The study was undertaken by researchers at the London School of Economics, led by Zack Cooper. They looked at whether hospital competition under Labour saved lives. They stated:

> "We find that after the reforms were implemented, mortality fell (i.e. quality improved) for patients living in more competitive markets. Our results suggest that hospital competition can lead to improvements in hospital quality".

I hope that when we get to the nitty-gritty of the Bill on Monitor we will approach the issue of competition a little more dispassionately than in the recent past and will consider the evidence and not just our prejudices.

4.25 pm

Baroness Emerton: My Lords, I thank the noble Lord, Lord Warner, for mentioning integration because, as my notes say, the recent Dilnot report findings and the title of this Bill—health and social care—are the chance in a lifetime for us really to grasp this in terms of crossing the boundaries between health and social care, particularly the boundaries with local government which are sometimes difficult to close, which really is necessary for the elderly, frail and infirm.

We have heard a lot this morning and afternoon about the details. There is no doubt that the devil is in the detail. I am quite sure that the House will scrutinise the Bill in the forthcoming weeks and that we will be able to come to a consensus view. I declare an interest as a long retired nurse and a fellow of the Royal College of Nursing. Apart from the noble Baroness, Lady Masham, who has raised the issue of support workers, we have not mentioned nursing much this morning or afternoon. I want to raise three things: the challenge that is currently being faced out there in the field with the Nicholson £20 billion savings, the cost of the new structural recommendations and the effect that they are having.

The Royal College of Nursing is already reporting large reductions in numbers of staff, which are not being replaced by nursing posts, and that specialist nurses are being redeployed from their nursing posts to do other duties. Thus, the patients who require the specialist nurse—particularly in breast cancer, multiple sclerosis and all the others—are suffering the loss of their nurses. Where there is no support available by family or friends, an integrated pathway leads from primary care, secondary care, tertiary care back to secondary care, primary care and social care. It does not favour the experience of an 84 year-old with very little mobility recovering from quite a severe stroke to be discharged on a Friday evening at 6 pm to an empty house, with the only toilet upstairs and nobody to care for her until Monday morning.

The Royal College of Nursing has demonstrated that where costs being driven down becomes an overriding factor and corners are cut at the expense of the quality of service delivery, as sadly demonstrated in the Maidstone, Tunbridge Wells and the Mid Staffordshire foundation trusts, patient outcomes and even safety come into danger. This also affects the culture within the organisation, where fear begins to take over. Incontrovertible research evidence from independent academics across the United Kingdom, the United States and Australia show the relationship between patient outcomes and registered nurse staffing levels. In order to guard against the possibility of further tragedies and failures in the management of correct nursing staff levels upon the wards, the Royal College of Nursing would like to see the Bill amended to include mandated staffing ratios and levels. The national Commissioning Board would specify guidelines and the registered to non-registered ratio would not fall below 55 registered nurses to 35 non-registered, and, on the higher dependency wards, 65 to 35. The local CCGs would also monitor and assess compliance and efficiency. The RCN would also like to see these staffing levels and ratios as set standards to be taken into account by Monitor and the CQC.

I now move to Part 7 of the Bill and Clause 231, which my noble friend Lady Masham has already mentioned. I want to explain in a little more detail what the Nursing and Midwifery Council feels is necessary. The council recognises that the Government have accepted that unregulated workers supporting healthcare professionals represent a risk to public protection that needs to be addressed through regulation. The suggestion of voluntary registers may provide a solution for some healthcare regulators but the NMC believes that voluntary registration for healthcare support workers carrying out tasks delegated by nurses and midwives is not sufficient to protect the public.

Clause 231 gives no indication that a voluntary system will be underpinned by consistent UK-wide standards of training that would assure the public and employers that health support workers have the knowledge and skill they need to practise safely. The NMC believes that a voluntary system would do little to prevent cases of serious abuse and failure by health service workers such as those illustrated earlier this year at Winterbourne View and in the Parliamentary and Health Service Ombudsman report *Care and Compassion?*. Only mandatory registration can provide the statutory powers that the NMC needs in order to take action against health support workers who pose a risk to the public.

The House of Commons Health Committee was unequivocal in its support for mandatory regulation. Its seventh report on the annual accountability hearing with the Nursing and Midwifery Council states:

> "The Committee endorses mandatory statutory regulation of healthcare assistants and support workers and we believe that this is the only approach which maximises public protection".

The Royal College of Nursing supports the regulation of healthcare assistants and support workers. I know that many noble Lords do too and that the public would support this. The Bill proposes the abolition of the 10 English SHAs. In so doing, the Government will need to take into account that the SHAs currently host the local supervising authorities' independent organisations responsible for ensuring that the statutory supervision of midwives is undertaken according to Nursing and Midwifery Council standards. We know that there have already been problems with the delivery of midwifery in some areas and the local supervising authorities play an important part in controlling standards. Any changes in the hosting and function of the local supervising authorities may necessitate legislative changes to the Nursing and Midwifery Order 2001 and the Midwives Rules and Standards.

On education and training, in their response to the NHS Future Forum report the Government stated that they will introduce an explicit duty on the Secretary of State to develop a system of professional education and training as part of a comprehensive health service. That will be crucial. However I urge the Government, when drafting the amendment, to consider the need for the Secretary of State to promote multi-professional education and training to ensure that the NHS can continue to develop a high-quality multi-professional workforce to support improved outcomes for patients and service users.

Evidence-based practice is very important and an evidence base requires research. Money must be available for multi-professional research as well as just for the medical side.

Finally, I thank the Government for the announcement made by the Secretary of State that there would be a chief nursing officer on the national Commissioning Board and a director of nursing at the Department of Health. However, I would like those two posts and the nursing post at CCG-level to be written into the Act, because the nursing and midwifery professions are

[Baroness Emerton]
currently not enjoying the confidence of the public in many places and are asking the same question as was asked by Florence Nightingale on entering hospitals in the Crimea—who's in charge?

The recognition of authority and accountability is important at service delivery level, as it is at the national board level. Very often, moral parameters get in the way and it becomes blurred. Eighty per cent of care delivered to patients is by nurses, and it is important to the public and patients, as well as the professions, that their leaders are recognised alongside other heads of professions and have equal voice at the table, with direct accountability to the chief executive or designated lead officer.

I therefore ask the Government to consider making the posts mandatory at national and CCG level. I am aware that the Government do not wish to be prescriptive, but that is necessary at this time to give reassurance to the professions, patients and the public that there is at least recognition of the position of nursing within the NHS. It is then up to the professions to ensure that they are worthy of recognition by delivering high quality, compassionate care.

4.35 pm

Baroness Kennedy of The Shaws: My Lords, I make a declaration that I am a fellow of three royal colleges, too, like the noble Baroness, Lady Cumberlege. I should also say that I am married to a surgeon who has spent his life in the National Health Service. He is from a dynasty of doctors. His grandfather was a doctor, his mother a doctor, his aunt a doctor and now our daughter is entering medical school. They all entered medicine not because they are interested in making money but because they want to care for people. It is the idea of being at the service of others that draws most health carers into medicine. They do not want to run businesses; they do not see their patients as consumers or themselves as providers. They do not see their relationship as commercial and they do not want to be part of anything other than a publicly funded and provided National Health Service.

Health professionals also feel proud, as all of my husband's colleagues do, that Britain is the only country in the industrialised world where wealth does not in some measure determine access to healthcare. They are saddened that the National Health Service is now facing the prospect of becoming a competitive market of private providers funded by the taxpayer. When we hear talk of accountability, they point out that nothing in the Bill requires the boards of NHS-funded bodies to meet in public, so there will be a lack of transparency. That will be complicated by the fact that private providers are not subject to the Freedom of Information Act, so they can cite commercial sensitivity to cover their activities.

Others have spoken of the removal of the duty on the Secretary of State to provide healthcare services and pointed out that that duty is now to be with unelected commissioning consortia accountable to a quango, the national Commissioning Board. The Bill does not state that comprehensive services must be provided, so there may well be large gaps in service provision in parts of the country, with no Secretary of State answerable. Providers will be able to close local services without reference of the decision to the Secretary of State. Although the Government say that the treatment will be free at the point of delivery—we hear the calm reassurances—the power to charge is to be given to consortia. That paves the way for top-up charging and could lead eventually to an insurance-based model.

Monitor, the regulator, is to have the duty to sniff out and eliminate anti-competitive behaviour—and, of course, to promote competition. According to the Explanatory Notes to the original Bill, Monitor is modelled on

"precedents from the utilities, rail and telecoms industries".

How is that for reassurance to the general public? If anything should be a warning that this spells catastrophe, it should be that this is another step in the disastrous selling-off of the family silver to the private sector, with the public eventually being held to ransom and quality becoming second to profitability.

The regulator, Monitor, will have the power to fine hospital trusts 10 per cent of their income for anti-competitive behaviour. Any decent doctor will tell you that for seamless, efficient care for patients, integration is key to improving quality of life and patient experience. The question is whether competition and integration can co-exist. Evidence from the Netherlands is that they cannot. There, market-style health reforms designed to promote competitive behaviour have meant that healthcare providers have been prevented from entering into agreements that restrict competition, so networks involving GPs, geriatricians, nursing homes and social care providers have been ruled anti-competitive. There is a fear that care pathways, integrated services and equitable access to care in this country will be lost when placed second to market interests.

Under the delusion of greater patient choice, people are to be given a personal health budget. I am interested to hear what happens if it runs out halfway through the year. Private hospitals will enter the fray as treatment providers and, as in other arenas, they will undoubtedly, as others have said, cherry-pick and offer treatment for cases where they can treat a high number of low-risk patients and make a profit—for example, hip and knee replacement, cataracts, ENT and gynae procedures.

It is essential in an acute teaching hospital to retain the case mix, though, so it will be the teaching hospitals that will also provide the loss-making services such as accident and emergency and intensive care and deal with chronic illness and the diseases of the poor, such as obesity—we can name them all. These are essential services but they are also very costly. An ordinary hospital cannot provide them if it does not have the quick throughput cases as well to maintain a financial balance. If relatively easy procedures go to private providers, the loss of revenue to the trusts will eventually lead to them being unable to provide the costly essential services. It will mean that doctors trained in these places are not exposed to all aspects of patient care. Private companies cherry-picking services undermines and destabilises the ability of the NHS to deliver essential services like, as I have mentioned, intensive care units, accident and emergency, teaching, training and research.

Clause 294 allows for the transferring of NHS assets, including land, to third parties, and the selling off of assets. Clause 160 allows for the raising of loans by trusts, so hospitals taken over by the private sector could be asset-stripped and then sold on, as happened with Southern Cross homes.

The removal of practice boundaries and primary care trust boundaries will mean that commissioning groups will not be coterminous with social services in local authorities, so vulnerable people are more likely to fall through the gaps between GP practices. GPs will also be able to cherry-pick by excluding patients who cost more money and can lead to overspend.

Then there is the issue of the cost of market-based healthcare. Advertising, billing, legal disputes—I say this as a lawyer—multimillion-pound executive salaries, dividends and fraud could end up consuming a huge amount of the pot that can be spent on front-line services. We will end up, as in America, with that extra stuff taking up 20 per cent of the health budget. The downward spiral of ethics, the increase in dishonesty and the conflicts of interest become huge, and you see the destruction of the public service ethos.

I want to scream to the public, "Don't let them do it"—and in fact the public are responding by saying in turn, "Don't let them do it". Market competition in healthcare does not improve outcomes. The US has the highest spending in the world and the outcomes are mediocre. The US overdiagnoses, overtreats and overtests. Why? Because that increases revenue. You change the nature of the relationship between doctors and their patients. You get more lawsuits and doctors therefore practise defensive medicine. You ruin your system.

I say this particularly to colleagues on the Liberal Democrat Benches. They may be being encouraged to think that voting against the Bill may bring down the coalition, but all I can say is that the electorate is watching. If people feel failed by the party on this, I am afraid that it will pay a terrible price.

This has been a 25-year project, done by stealth. It started with the internal market and is now moving to the external market. It was not thought up by mere politicians but by the money men, the private healthcare companies and the consultancies like McKinsey—the people, in fact, who in many ways brought us the banking crisis. They have funded pro-market think tanks and achieved deep penetration into the Department of Health, into many of our health organisations and right into some of the senior levels of my party as well as those on the other Benches.

The NHS is totemic. It is about a pool of altruism and it speaks to who we are as a nation. It is the mortar that binds us in the way that the American constitution does the American people. For us, it is about this system. It really is the place where we are "all in it together"—one of the few places, it would seem at the moment. Doctors get 88 per cent trust ratings with the public, while politicians get 14 per cent. The vast majority of doctors are saying to us, "Withdraw this Bill". We should be listening.

4.45 pm

Lord Mawhinney: My Lords, as this is a debate, I thank the noble Baroness, Lady Murphy, the noble Lord, Lord Warner, and my noble friend Lady Cumberlege for their speeches. All three recognised that there are serious issues that need to be addressed in and by the Bill. However, across the House they also dealt robustly with the probably unprecedented, in my experience, level of scaremongering that has been attached to this legislation. As I listened to my noble friend Lady Bottomley, I thought of when we worked together in Richmond House and her skill in taking a complex set of issues and having a timely word to say on each of them.

I shall focus my remarks rather more. I join others in congratulating my noble friend Lord Howe on the masterful way in which he introduced the debate. On a Bill that is, as we have heard, contentious, he carried the whole House with him. Everybody listened attentively, which reflects the personal standing in which he is held. I thank him. I am sorry that the noble Baroness, Lady Thornton, has just left; I want to congratulate her, too. I hope that the noble Lord, Lord Hunt, will tell her that while I did not agree with everything she said, the tone that she adopted was excellent. I say to her and my noble friend the Minister that if they are able to persuade the House to maintain that tone through what are likely to be very long hours, this place will do a service to the British people.

Turning to the Bill itself, I start by welcoming the emphasis that my noble friend placed on outcomes. Those of us who have served in Richmond House have had the slightly depressing experience of being forced, not least in the other place, to talk about health in terms of beds, buildings and money, as though they were the characteristics that determined the excellence of the health service. They all play their part but nobody would talk about outcomes. If this legislation leads to that cultural and significant change in this country—so that we start talking about outcomes—the work of this House and the Government will long be remembered. What we are concerned about are patient convenience, patients treated and patient outcomes.

Secondly, I welcome the fact that this legislation includes real delegation from the Secretary of State. I say real delegation because we live in a slightly make-believe world, in which SHAs and other bodies claim to have delegated power. I was not sure when I was in the department and am still not sure how real that delegation is. However, now it will be real. I hope that the Government understand that real delegation means legal liability, responsibility and accountability, judicial reviews and all the other aspects that go with a statutory framework. That will be a positive development but we ought not to skip over the likely consequences of this significant change.

I very much welcome commissioning. The Minister commended it and the important role that GPs have in developing healthcare. So did the noble Baroness, Lady Thornton, on behalf of the Opposition. This particular bit of the legislation got off to a slightly inauspicious start when, in the Second Reading speech in the House of Commons, the Secretary of State talked about fundholding having "failed to promote quality". Having told him to his face that that is not my memory and having been encouraged by my noble friend Lady Bottomley in that conversation, my main evidence that putting GPs in charge of fundholding improved quality lies with the honourable and right

[LORD MAWHINNEY]
honourable friends of noble Lords opposite. As fundholding increased, all they did was to complain and whinge about the fact that we now had a two-tier system. If my memory serves me right, Liberal Democrat colleagues joined in.

We had a two-tier system because the quality being delivered by fundholding GPs was so much better than that which was being produced by non-fundholding GPs that the difference was stark. If I have a regret about the Major Administration it was that in the summer of 1994, when more than 50 per cent of GPs were already in fundholding, the Prime Minister—how do I put this delicately?—did not see the need to drive the successful programme to a conclusion. Had he done so, by the summer of 1995 all GPs would have been fundholders and we would not be having this debate today.

I understand the need and case for a national Commissioning Board. I am not sure what is going to be the relationship between the national Commissioning Board and the CCGs and the relationship between the CCGs and the individual GPs. I see a lot of opportunity for conflict and I hope that, as we go through Committee, the Minister will be able to clarify those relationships. We do not need a new set of bureaucratic institutions which get in the way of the demonstrable ability of GPs to do what is best for their patients. In the health service, GPs are probably the only people who genuinely personally care for patients.

Can I tell my noble friend how pleased I am that PCTs and SHAs are going? This is long overdue. I read stories about the health service in the media and I do not know whether they are true, but I know what is going on in my old constituency. I am not impressed—and I do not think that a lot of people are—by a PCT that managed to get itself £20 million into debt, and an SHA that did not notice and does not know who was responsible and does not care because it is in the past. So well done for getting rid of them, but you need to do something about them between now and the implementation of this Bill.

A lot of nice things have been said about Sir David Nicholson and the Nicholson challenge. There is one small example. The East of England SHA has decided to amalgamate the Peterborough and Cambridge PCTs. Nobody wants this. In Peterborough it did not consult the primary care trust. It did not consult the Peterborough hospital. It did not consult the Peterborough council. It just did it, Sir Neil McKay tells me, because it would save some money. This is probably a small bit of the Nicholson challenge. When I asked the Government about this in Parliamentary Questions, I was told to go and ask Sir Neil McKay, whose behaviour within the SHA prompted a lot of the questions in the first place.

Minister, there is much to welcome and much to discuss and clarify, but thank you for an excellent start.

4.55 pm

Baroness Kingsmill: My Lords, as a former deputy chairman of the Competition Commission, I am of course a strong believer in the positive effects of fair competition in most markets. However, we must remember that competition, red in tooth and claw, may not be the most appropriate thing for the provision of public services because competition unregulated tends to end up with the most aggressive monopolist. We must remember that regulation has its limitations. As a former regulator, I know only too well just how limited regulation is. The trouble with regulation is that you are always regulating for the past crisis, not for the next one. I have just come down from the Economic Affairs Committee where we are interrogating the chief executives of our banks. If ever we saw a failure of regulation and the problems that we have in regulating a marketplace, the banking crisis that has arisen from the behaviour of our banks should give us pause. We all tried to regulate them; we all tried to control their behaviour. We failed.

I am not impressed by the regulatory elements in the Bill and I am not impressed by Monitor. It seems at the present moment to be a somewhat underpowered regulator. For something as sensitive as the NHS, if competition is to be introduced, we need to be very careful about how we regulate it. We need a remit for the public interest over and above anything else. An overweening public interest requirement must be the first issue that any regulator in this marketplace must consider. A mandate to prevent anticompetitive behaviour is simply not enough. There will always be the means by which anticompetitive behaviour arises without being apparent in clear ways.

It is also important to recognise that regulation has its limits, but a level playing field is important in the first place. At present, it does not appear that there is a level playing field with fair competition. Large health providers will be competing with current NHS providers that will not have the same access to funds and bank financing. This means that there will not be a level playing field or fair competition and it will be much too late to regulate for this afterwards.

It also concerns me—again as a former chair of an NHS trust—that a great number of very unpopular services will have no adequate compensation. I was the chair of Optimum Health Services, which was a community trust. It was the sister trust—the very poor sister—of Guy's and St Thomas'. Our remit was to provide community services in one of the poorest boroughs in London. The sorts of things we were concerned with were chiropody for the elderly and incontinency services. We were forced under the previous round of Conservative changes, with the introduction of the internal market, to figure out ways of reducing the number of incontinency pads provided to our clients from six a day to five a day. That was the kind of decision we were being forced to take. I cannot see very much competition for the provision of services such as those being apparent.

It is all very well for us all to talk about market forces and competition as if somehow that will be the answer to everything. However, I have seen from direct experience that it very rarely is the answer to everything. We do not do a good job of regulating our public services in this country. We have only to look at the railways to see that. We do not do a good job and I cannot see anything in the Bill so far that allays my fears.

I have been in the House only for five years but I have received more letters over this issue than any other one and somehow people seem to have got hold of my personal e-mail as well. I am overwhelmed with e-mails and letters and they all say the same thing. Some of them are emotional pleas along the lines of "Save our NHS" which are perfectly understandable but many of them are from individuals and organisations who are very well informed both about the Bill and the NHS. They have come forward with very powerful arguments as to why this is not appropriate for them. They are strong, well reasoned arguments and I feel we are obliged to take note of them. That is why I support the amendment of the noble Lord, Lord Owen. It would be entirely appropriate for us to have a Select Committee where people could come forward and give proper evidence, have it heard in public and televised if necessary so that a full and clear debate about these issues could be had—not simply rushed through with the inadequate scrutiny we have had both in the other place and here. We are all trying our best but quite frankly we just have not had the time. This is a Bill that could fundamentally change one of the pillars of our society and I do not think we have had enough time to look at it. The very modest and sensible suggestion made by the noble Lord, Lord Owen, is one we should all support.

There are other elements of the Bill that concern me greatly. I have some anxieties about the lack of close attention being paid to the problems of conflict of interest. I am very concerned about the possibility of GPs having a financial interest in the providers they may be commissioning. In Australia and New Zealand—I am a New Zealander—that is not allowed. It is expressly forbidden—you cannot have a financial interest in a body you commission. That is a very important thing that seems to be completely missing in the Bill.

We should also recognise—this is something that those who have worked in the NHS will realise—that it is more change. It takes ages and ages for these sort of changes to filter through and actually take place. It is costly, upsetting, damaging and unless you are absolutely certain that the outcomes are going to be improved it should not be embarked on lightly. I have grave anxieties that we are all going too far, too fast.

5.03 pm

Lord Willis of Knaresborough: My Lords, I first declare an interest as the chair of the Association of Medical Research Charities. Judging by the number and passion of the communications that I and other Members have received you could be forgiven for believing this Bill was drafted in Hades by the most malevolent lawyers urged on by Ministers hell-bent on destroying the whole of the National Health Service. It simply is not that at all. Many of the same arguments were deployed against the Darzi health reforms of the previous Government—in fact many of the demons now being prayed in aid by the noble Baroness, Lady Kennedy, and others were Labour creations. The fact they were does not mean they were wrong or ill conceived, and the same can be said for much of the current Bill. It is our job to ensure that we scrutinise it fully and we are only just starting that process.

However, then as now, it was the failure to communicate what the reforms were trying to achieve that was at the heart of the discontent, not the motives to improve our health service. It is the confusion and complexity of these reforms that my noble friend must address if he is to convince the House that benign evolution rather than malevolent dogma lies at the heart of this Bill. However, evolution must not imply a lack of urgency or boldness. We can discuss organising commissioning groups in whatever configuration we like but, unless we can deliver to our clinicians the fruits of the most productive health and medical research base in the world, they will lack the tools that they need to truly deliver 21st-century health and social care.

Put simply, if patients are to be the new focus, as the Minister rightly says, they must be the beneficiaries of the work of our research community. In 1975, Milstein and Kohler at the MRC lab in Cambridge developed monoclonal antibodies, able to target individual proteins in the body. Following clinical trials using the NHS database, the technology was made available for therapeutic use and today monoclonal antibodies account for one-third of all new treatments, including ground-breaking cancer therapies such as Herceptin and Rituxan. Closer to home, few in your Lordships' House will not live longer and healthier as a result of the work of the MRC scientists and the British Heart Foundation, whose large-scale study using NHS patients revealed the relationship between cholesterol and heart disease. Today the wide-scale prescription of inexpensive statins not only reduces the risk of cardiovascular disease for millions but substantially reduces costs for the NHS.

Whether it is the use of induced pluripotent stem cells to find a cure for Parkinson's disease or stem cells to regenerate bone and cartilage in arthritic patients, translating research into clinical practice faster is what will really make a difference to patients, whoever they are and wherever they come from in our NHS. How right the noble Lord, Lord Darzi, was when he said in his excellent speech this morning that "healthcare resides at the edge of science". Yet this Bill is woefully weak on scientific research and the use of the NHS database. True, we now have Clause 5, which places a duty on the Secretary of State to promote research. A parallel duty to promote research is placed on the NHS Commissioning Board and the clinical commissioning groups—but this is merely window-dressing, without real substance.

The UK's universities and hospitals, vibrant medical science industries, strong health research charities and a unified healthcare system have all contributed to our status as a world leader in health research. Recent surveys by MORI for my organisation have shown that 72 per cent of patients are willing to join clinical trials and 80 per cent would consider allowing researchers to access their medical records. But efforts to do so are seriously undermined by an overly complex regulatory and governance environment. It takes an average of 621 days to recruit the first patient to a cancer trial, according to CRUK, largely because the regulatory environment has evolved in a piecemeal manner over several years as new regulatory bodies have been introduced. The net effect is a fragmented process characterised by multiple layers of bureaucracy,

[Lord Willis of Knaresborough]
uncertainty in the interpretation of individual legislation and guidance, a lack of trust within the system, and duplication and overlap of responsibilities.

Most importantly, there is absolutely no evidence that these measures have enhanced the safety or well-being of patients or protected the public. Quite the opposite—duplication in obtaining permissions from NHS trusts and other regulators simply creates confusion and unnecessary delays. As a result of this "one size fits all" approach, there has been a fall in the UK's global share of patients in clinical trials and an increase in the time and cost of navigating the UK's complex research approval processes. That flies in the face of the idea that we get better outcomes for our patients.

In short, the current situation is stifling research, driving medical science overseas and seriously disadvantaging the very UK patients whose lot we in this House want improved. This Bill could and should deal with these issues by translating into statute the recommendations of the Academy of Medical Sciences. At the centre of its proposals was the creation of a new single research regulator to oversee and manage the regulation and governance of all health research; to deliver on opportunities to reduce complexity, costs, timeliness and inefficiency; and to build confidence in the conduct and value of health research. What is frustrating is that the Government are so supportive of that approach, but there is no sense of urgency to actually deliver. The promise of a Bill at some future date is simply not acceptable unless the Minister can put on record, when he winds up tomorrow, that it will be in the next Queen's Speech.

Setting up a health research authority as a special health authority is welcome but, apart from finding a home for the Medical Ethics Service, it answers few of the fundamental questions raised by the Academy of Medical Sciences. Equally, plans to improve the NHS R&D permissions process by making future funding conditional on NHS trusts meeting new approval timelines is very welcome, but how autonomous trusts will be persuaded to fast-track approvals is far from clear. What if the new commissioning groups say, "Research is not our priority"? How will the Secretary of State, without those powers, deal with exactly that? During Committee, I hope that amendments will come forward to consider setting up a new authority, though I recognise that unpicking our existing governance framework in order to streamline it will require a phased approach, the transition of several functions, and therefore co-ordination between a number of bodies. It will also mean dealing with the fall-out from the Public Bodies Bill, which seems to have been forgotten, and dismantling organisations such as the Human Tissue Authority and the Human Fertilisation and Embryology Authority. However, the academy has created a clear vision so that all those involved in undertaking research are clear on the end-point we are aiming for, and what is expected of them during the transition.

My noble friend has said that he wants to listen and that he wants to make necessary improvements to this Bill. He can become a hero in the medical community. He can become a god among patients, if he listens and takes our advice—and that is probably the best advice that he is going to get today.

5.12 pm

Baroness Warwick of Undercliffe: My Lords, the Secretary of State in another place said that this Bill should aim,

"to improve the health of the people of this country and the health of the poorest fastest".—[*Official Report*, Commons, 31/1/11; col. 605.]

Of course, all sides of this House would support such an aim. We can all agree that reforms of the NHS on some key issues are needed. When in government, my party started the current programme of reform to improve quality and productivity in line with the increased investment we made in the NHS.

Yet the changes to the NHS proposed in this Bill present us with a very different reality. Judging by my postbag, these changes have signally failed to engage the support of those in primary care, and have created huge anxieties among the people of this country. The Secretary of State has said that he wants,

"to move forward with the support of doctors, nurses and others who work in the NHS".

Eminent clinicians and other medical professionals in their hundreds have shared with us their belief that the Bill as it stands will do irreparable harm to the NHS, to individual patients and to society as a whole.

I share, but do not intend to repeat, the many concerns voiced during this debate. Instead I want to focus on proposals which seem to me to impact particularly on education and training in the NHS. I am deeply anxious that the radical reorganisation proposed by this Bill will undermine the current UK-wide system of high level education, training and research. In particular, I am dismayed that we still do not know what will replace the strategic health authorities, responsible for the bulk of education and training. The SHAs host the postgraduate deaneries, which deliver postgraduate medical education, and which are responsible for the continuing professional development of all doctors and dentists. The intention seems to be that local skills networks of employers will take on many of the workload functions currently undertaken by the SHAs.

I cannot help but think that this is the wrong reform at the wrong time. The highly effective deaneries are able to tailor their workforce planning via local schemes within regional frameworks. I cannot see how the provider skills networks will do this more effectively or efficiently, particularly as there is no requirement for the networks to work with higher education institutions—the UK's centres of scholarship and academic expertise.

Professional leadership in medical education, based on co-operation between the medical royal colleges and deaneries, is currently very strong. Devolving responsibilities to networks of providers would certainly weaken this. I know that the coalition has given a commitment that deaneries will still have oversight of the training of junior doctors pending further changes, but the long-term future of these deaneries is still uncertain. The "safe and robust transition" for the education and training system, promised by the coalition following the Future Forum, has still to be made clear. Indeed, the Future Forum said explicitly that education and training needs to be service sensitive but professionally and academically informed. I also say that I very much

support and endorse the remarks made by the noble Baroness, Lady Emerton, about multiprofessional education and research.

I believe we could see fewer opportunities for education and training if the number of new providers of NHS services increases, as this Bill invites. There is real danger of conflicts of interest if training shifts to being employer led. Being "service dominated" rather than, as I believe it should be, "service informed" risks stagnation of educational provision and the danger of not addressing future workforce needs. I also fear that local employers would lack the necessary broad overview of medical workforce requirements, particularly given that specialist training can be as much as ten to 15 years following graduation.

The management, planning and oversight of the medical workforce can only be done at national and, more properly, at UK level. Can the Minister, in his response, explain whether there will be an explicit duty on the Secretary of State to retain a national, UK-wide system of high-level education and training? As we are discussing the duties of the Secretary of State, I remind the Government that it is the responsibility of the Secretary of State for Health to make available, in premises provided by him by virtue of the National Health Service Act 1977, as amended by subsequent legislation, such facilities as he considers are reasonably required by any institution in connection with clinical education and research.

That brings me to another area of concern, which is research. I am pleased to follow the noble Lord, Lord Willis, in his spirited advocacy for research. It is vital—for patient care but also for the economy of the UK—that research is not overlooked as we debate this Bill. The structural changes to the NHS proposed in this Bill could, as I see it, be a threat to the UK's important biomedical research industry. We must ensure that every healthcare provider has a duty to train the next generation of doctors and nurses. Having a research culture embedded in the NHS, from the Secretary of State to clinical commissioning groups, is vital if we are to tackle some of the health challenges we face.

At the same time, the NHS's consultant and professorial teaching staff must be incentivised to remain in the UK. The Secretary of State has had a report into the clinical excellence award scheme from the Review Body on Doctors' and Dentists' Remuneration on his desk since early July. Withdrawal of these awards would have a catastrophic effect on clinical academic careers and would immediately threaten the UK's pre-eminence. I hope that the Minister will confirm that the Government do indeed value their research workers and will take the necessary steps to ensure that the UK remains competitive.

I said that I would not repeat the concerns of others, but I wish to add my voice to those calling for further scrutiny of the duties of the Secretary of State. I believe the House must consider seriously the unanimous conclusion of the all-party Constitution Committee. The duty to,

"provide or secure the provision of services",

has been placed on the Government since the NHS was established in 1948. For more than 60 years, people have known that the Secretary of State and the elected Government are responsible for defining and providing a comprehensive health service.

The proposed change of wording is not simply a question of being pragmatic about how decisions are made. This is not about a nice distinction between the duty to provide and the duty to secure that services are provided, as the Minister in his opening remarks seemed to suggest. It goes to the heart of who takes responsibility for a national universal health service. I believe passionately that the Secretary of State must retain the duty to provide these services. In this way, ministerial accountability, responsibility and legal accountability are maintained.

Therefore, I support the amendment to the Motion that would refer that section of the Bill to a specially convened all-party Select Committee. This remains one of the most contentious aspects of this very controversial Bill. It is essential that we take the time to get it right.

5.20 pm

The Earl of Sandwich: My Lords, I start with a health warning: prescribed drugs can kill—a message which I recommend that all GPs pin up in their surgeries forthwith. The Minister already knows why I am saying this and why I have entered this debate today, and I will try not to repeat what I have said in this House previously. I will explain later how my intervention fits into the Bill and may lead me to put down amendments. I apologise to the Minister and to the House that, because of minor surgery, I will not be able to attend the wind-up speeches tomorrow.

Just over a year ago, as vice-chair of the All-Party Group on Involuntary Tranquilliser Addictions, I put the case for a vulnerable group in society which I feel has been virtually ignored by the health service. In most cases, these people—including a member of my own family— have been left in their homes in intolerable pain. These non-patients, through no fault of their own, have become victims of addiction to and withdrawal from prescribed drugs, such as benzodiazepines. There are an estimated 1.5 million people at risk, including many whose doctors and psychiatrists connive at overprescription and are then, it seems, incapable of coping with its ill effects. It is a scandal that has been known about since the 1960s. What are the Government doing about it?

To be fair, the Ministers responsible—Ann Milton and the noble Earl, Lord Howe—have both given me personal encouragement by way of letters and meetings during the past year. I sincerely believe they would like to make some headway. Earlier this year, the Department of Health published two reports by the National Treatment Agency and the National Addiction Centre, but these reports take us no nearer to policy-making. In reviewing the evidence, they were unable to identify the size of the problem or to separate legal users of prescribed medicines from illegal substance misusers. Apparently, the number of prescriptions is available but the number of patients—which is held on the GPs' databases—has been left unanalysed. So what benefit has there been for the patients from these reports? There are none that I can see. They are not a threat to society, so the suspicion must be that they are therefore lower in the order of priorities than illegal drug addicts, who are the only beneficiaries of the Government's drug strategy and, of course, of public money. Yet the pain of

[The Earl of Sandwich]
withdrawal from prescribed drugs can be far worse than withdrawal from heroin, so there is blatant injustice in the system.

I also believe there is a gap in understanding between the department and its related health services, and this is relevant to the wider debate about tiers of authority. I give one example. My family and I have tried to put together research on the extent to which limited services for benzodiazepine patients exist in places like Oldham, Bristol, Cardiff, Belfast, Newcastle and the London Borough of Camden. I noticed that the Department of Health included Wandsworth in its list, so I telephoned the number it gave me. I was subsequently given three more telephone numbers and was finally advised by the PCT to contact the addiction centre in Roehampton, which advertised the service. One visit was enough to prove that the service did not actually exist. The psychologist involved admitted that it was a gap, and that they would have to take advice on setting up such a service.

Can this situation be a one-off? I suspect not: it is clear that other addiction centres do not have the necessary expertise. They have not had to deal with, nor been trained in, benzodiazepines except as part of a cocktail of illegal drugs. They will have experts in hard drug addiction and substance misuse, who either turn away occasional prescribed-drug patients or give them inappropriate and dangerous cold-turkey treatment, as happened in our case. The specialised services that exist are mainly independent of the NHS and are largely staffed by volunteers who have suffered withdrawal themselves and who, through that experience, have become the experts. A few work with their local PCTs or are funded by them and are properly recognised as the best practice in their area, but most counties in the UK simply do not have these services.

What is the expertise? In the case of addiction, the most important thing is gradual withdrawal with careful tapering and psychological support. The expert manual on tapering was written by Professor Ashton of the University of Newcastle. Patients need places to meet addiction workers—ideally in specialised clinics, existing multipurpose centres or church halls—and they need help with transport. Counselling by telephone or e-mail is important. It is not ideal, but helplines and the sharing of experience online enormously help those who spend long hours alone in their rooms in pain. Alternative therapies are available through the NHS, but these are not always appropriate in connection with prescribed-drug addiction. Families need professional support as well.

This is where the Bill comes in. At a time of economic cutbacks, we should be paying much more attention to these voluntary services, which provide real value for money. This Government evidently want to increase the role of the private sector, and that includes local voluntary agencies, but how will local authorities and CCGs cope if there is no national plan or funding? The health service created the problem of prescribed-drug addiction, so why can it not find the funding and design best practice to help its victims? Services may be managed by individuals who run their own charities and are not subject to direct management control by the NHS. Not-for-profit organisations are already within the network of healthcare in this country and need not be subject to the controls and regulations which in effect strangle many existing frail voluntary services.

I would therefore like the Government to give much more encouragement to the people who are already working on the front line to help the victims of prescribed-drug withdrawal. These services, I can testify, are of a high standard and should go straight on to the list of qualified providers. It is time for the DoH to recognise them and organisations like them throughout the health service and give them support.

5.28 pm

Baroness Gibson of Market Rasen: My Lords, in the 11 years since I joined your Lordships' House, I have never received as much correspondence on one piece of legislation as this Bill has generated. I have had hundreds of letters, e-mails and telephone calls about the Bill from individuals and organisations. Some have asked, indeed begged, me to oppose the Bill as a whole, others have picked out large chunks or particular clauses of the Bill, and only one e-mail has asked me to support the Bill in its entirety. If I had ever had any doubts about the love of the British people for the NHS before, I would have none now. The NHS is not only dear to our hearts but a fundamental part of our nation. I do not have the expertise about the NHS which many others in the debate have, but I respect and admire it and those who work in it. I have only a few matters to comment upon, about which I have some knowledge.

I will begin by declaring my interest as the honorary president of the Dispensing Doctors' Association. Its members live and work in rural areas of our country and are a vital part of the NHS. For a great part of my life, I have had the services of dispensing doctors. I still have very fond memories of my first doctor, Dr Shegog, in his surgery in Market Rasen with its spluttering gas fire in the waiting room, handing out what, in those days, always seemed to be foul-tasting medicines, which seemed to do the trick. We are talking about a comprehensive health service, and it must include the health service in rural areas. The legislation before us has to be rural-proofed, and we must consider how it will affect rural doctors and their patients.

The Dispensing Doctors' Association values the principles of clinical leadership and choice, on which the reforms are based. The DDA absolutely agrees with the principle of "No decision about me without me" and the need for true patient choice. Rural patients depend on the services provided by dispensing doctors, and the DDA believes that several of the Bill's principles tie in directly with the needs of these patients. It considers it essential that the final legislation supports and promotes joined-up services and therefore better patient outcomes for rural patients. However, the DDA was not consulted directly during discussions on the Bill, and therefore much of it appears to be pharmacy-based rather than dispensing doctor-based.

In the rural health system, the DDA knows that dispensing patients want a choice in where they collect their medicines. For many, travelling to a pharmacy is not always the most convenient option and requires a

separate trip in addition to the original GP appointment. Patients in rural areas overwhelmingly support collecting medicines from their dispensing doctor. In 2008, more than 60,000 patients wrote to the Department of Health in support of dispensing practices. Regulations need to be addressed to ensure that all rural patients have access to choice. If "No decision about me without me" is to become a reality, all rural patients should be able to choose where and from whom they obtain their medicines—a dispensing doctor or a pharmacy.

There is a clear need for integrated service provisions for rural patients and for clear guidance from the Government on how these can be promoted. A joined-up approach for dispensing doctors and pharmacies is crucial to ensure that patients receive care in the most convenient location for them, and this should be assessed locally as part of the local authority remit. Failure to address this will lead to an increase in health inequalities. I hope that the Minister can reassure me on these points in relation to rural health service practices.

Turning to industrial relations—a key element in the success or otherwise of the proposals in the Bill—UNISON, a major union in the NHS that represent thousands of its vital workers, believes that the Bill is,

"a major threat to the future of our National Health Service",

because of the dangers it introduces of fragmentation, instability and inequity. These fears stem from UNISON's membership, and those members should and must be listened to and considered as we debate the Bill. If those who work in the NHS do not believe in its aims and aspirations, it will not work.

What are their major fears about the Bill? Under the planned reorganisation, NHS staff face nearly 13,000 redundancies, according to the Government's own statistics, and of course the numbers will treble when the workers' families are taken into account. The Government do not acknowledge the need for the retention of national workforce structures for terms and conditions, pay and bargaining. This is foolhardy in the extreme. Workforce turmoil helps no one, while a contented workforce brings benefits to all. "Dedicated" is a word that is often used in relation to the NHS and its workers, and indeed they are dedicated. However, we cannot expect this dedication to continue if they feel undervalued and undermined.

A further and real fear surrounds the removal of the cap on private patient involvement. When the cap was established, its aim was to stop hospitals pushing NHS patients to the back of the queues, which are already lengthening. If we are not careful, "Can pay, will pay" may well become a future catchphrase about the NHS, to the detriment of NHS patients—a danger that is acknowledged in the recently revised impact assessment.

There are fears, too, about the NHS being based on competition, not co-operation, because of the market system established in Part 3 of the Bill. I know that other noble Lords have spoken about this area. Surely the Government should be promoting co-operation and collaboration rather than competition. Is there to be a rationing of care because of this competition, and what does the term "any qualified provider" really mean? Additionally, the larger role envisaged for the private sector brings a chill to many a heart. Have we learnt nothing from the awful events at Winterbourne View and Southern Cross?

Of all the other briefings that I have received, I believe that the one from the Coalition of UK Medical Specialty Societies is of prime importance. The coalition is a group of professional bodies representing clinicians and other health professionals working within the NHS who would like to see,

"healthcare reforms that ensure the best care for their patients".

Key points made in this briefing are that: for the overwhelming majority of the coalition's patients, having access to high-quality and suitable care is paramount; patients' choice must be real and informed—patients should know the details of the experience and qualifications of those who treat them; choice must be for the patients rather than the provider; competition could result in the fragmentation of patient care, and many different providers could make it harder to deliver integrated care and prevent health professionals working together in multi-disciplinary teams; and continuity of care must remain a high priority among all providers.

I end by agreeing with the Minister, the noble Earl, Lord Howe, on one thing; the NHS must remain patient-centred above all else.

5.36 pm

Lord Black of Brentwood: My Lords, it has been a genuine privilege today for me to listen to so many speeches from noble Lords with distinguished records of service in the health sector, either as clinicians, former Health Ministers or specialists, and to hear their views. Like my noble friend Lord Rodgers, I am afraid that I am just a layman. I can offer no such professional input to match this canon of wisdom but speak simply as a consumer of the NHS's services, as indeed were my late parents.

As I prepared my remarks, I thought in particular of the care that the NHS provided for my mother during a range of illnesses as she grew older: osteoporosis, heart failure, osteoarthritis, a transient ischaemic attack or mini stroke, and chronic obstructive pulmonary disease. It was that personal experience of the weight of these conditions that brought home to me in the most vivid fashion the extraordinary financial demands that are placed today on our health services as patients live longer and contract age-related illnesses in a way that would not have been the case only a few years ago, let alone in 1946 when the NHS was formed, and how in turn that places huge human burdens not just on GPs but on emergency departments, geriatric wards, carers and others involved in the vital chain of support for older, frail people and how they all work together.

It is of course a cause first and foremost for celebration that some 65 years or so since the founding of the NHS the advances in care and treatment, and above all in public health, have produced longer and more fulfilling lives for so many people. However, one central truth flows from that—the NHS has to change in order to survive. It is, after all, reaching pensionable age itself, and a new way of life is needed.

I come from the world of the media. In recent years we have seen at first hand how the dramatic changes in technology, lifestyle and demographics have shattered

[Lord Black of Brentwood]
the business model that supported media companies. We have had to enter a period of permanent evolution—changing the way we do business and changing the services we offer our readers and customers—just to survive.

The same is true in the NHS. Demand is growing rapidly. Long-term conditions of the sort I mentioned earlier and that consume about three-quarters of the entire health budget are becoming more common. The renewal and regeneration of our great National Health Service is not just an option; it is essential. My noble friend Lord Mawhinney talked earlier about scaremongering. If there is something that we should be scared about, it is that we fail to change.

Osteoporosis—a subject about which I care deeply—is an excellent example of what I am talking about. As the population becomes older, this terrible illness becomes more prevalent. Between 1999 and 2009 the number of bed days attributed to hip fractures increased by 32 per cent. As our population rises by 17 per cent, it is projected that in England they will increase by a further 100 per cent between now and 2036, by which time treating and caring for hip fractures in the UK could top over £6 billion a year, which is a huge figure when considering the current burdens on the NHS. Broken bones already affect a greater number of older people than both heart attacks or strokes and TIAs. Osteoporosis is a costly disease, not just in straightforward economic terms but in the impact on individual lives, and that pressure will grow.

There could not be a more pertinent example that makes it obvious, even to non-experts such as me, that the NHS will have to change if it is to survive another 15 years, let alone another 65. That is precisely what this Bill is all about. Change means that it has to become more efficient, more focused on the challenges of public health and more accountable, and above all that there has to be a greater voice for patients who, in my view, are acutely aware not just of how much they owe the NHS but how it can be made even better.

I believe that this Bill delivers those ends, and that it does so in a way that should command widespread support. After all, as my noble friend Lady Bottomley reminded us earlier, the extension of choice and competition are not new principles; those of all parties and of none have long supported them. Involving GPs in clinical care is not new. GPs have been providing increased ranges of services for many years, and this Bill provides a logical and coherent extension of their powers rather than the piecemeal approach we have seen in recent years.

I spoke just now about the issue of osteoporosis, a subject that I raised in my maiden speech in this House and have talked about on a number of occasions since. To give a personal example, that one subject provides a prism through which we can see in a practical way how this Bill can help with one of the most chronic and debilitating conditions that are at the root of the need for reform of the NHS. Let me explain why. Giving responsibility to GPs for commissioning health services is giving responsibility to precisely the people who can spot this condition early and initiate treatment for it. They can play a pivotal role in the prevention, diagnosis, treatment and care of patients who are at risk of broken bones, for osteoporosis can be reduced only by involving professionals from a range of settings in the commissioning process.

Of course, GPs are not alone, and many fractures originate in care homes. Adult social care professionals need to be involved too, and the health and well-being boards, which this Bill will introduce, are a perfect way to bring stakeholders together to oversee local fracture services; and clinical senates will be able to act as vehicles for cross speciality collaboration, strategic advice and innovation to support commissioners in local areas. These are developments of real value to the patients of the future, and they spring directly from this Bill.

I also welcome the proposals to increase the amount of choice and information available to patients. Patients with, or at risk of, broken bones should be able to access information about the quality and outcomes achieved by their local services, and this Bill will deliver that. That is a very welcome step for the hundreds of thousands of people who suffer from osteoporosis.

Of course, issues will need to be raised in the Committee stage of the Bill, which quite rightly should take place on the Floor of the House, where, as the noble Baroness, Lady Murphy, said earlier, we have experts to deal with these issues. I highlight in particular the provision of information about whether local hospitals or GP surgeries have fracture prevention services in place. I believe that steps must be taken within the scope of the Bill to ensure that the ability to choose the location in which care is provided is extended to disadvantaged groups, including the frail and immobile. I also hope that the Government will include indicators that measure admissions for fractures in older people in their initial NHS adult social care and public health outcomes frameworks, but these are issues that can be sorted out.

The key point is that with a long-term condition such as osteoporosis—I have deliberately used this as a personal and practical example—the Bill will, for the first time, put in place a framework that will allow us to improve lives through early diagnosis, greater accountability and the cohesion of care services. That is a precious prize.

Of course, as we have heard, this Bill is controversial. Change always is, but if we really care about something—everyone in this House cares about the NHS—we must have the courage to face up to that. If we fail, we will be letting down not just ourselves but those who will come after us.

5.44 pm

Lord Hutton of Furness: My Lords, I declare an interest in that my wife is director of Nuffield Health, the independent healthcare charity.

I very much agreed with the speech of the Minister when he said that the biggest challenge that the NHS currently faces is how to improve patient care against a background of significant improvements in efficiency. If we agree with that, the question for us all is: how will this Bill, in its current form, help the NHS to meet that challenge? Today I have not heard a sufficiently convincing answer. I say that with very considerable regret.

I agree with the noble Lord, Lord Black, that the NHS will need significant change in the future if it is to meet this enormous challenge, which is both economic and demographic. It will need effective competition if it is to stimulate new thinking and new ideas. It will certainly need greater local freedoms from the centre to support the necessary innovation, and it will certainly need less bureaucracy. Sadly, I am not sure that any of these useful objectives are likely to happen under the Bill in its current form.

My noble friend Lady Warwick of Undercliffe drew our attention to the speech of the Secretary of State for Health when he introduced this Bill in the House of Commons. He rightly and properly said that the Bill was designed,

"to improve the health of the people of this country and the health of the poorest fastest".—[*Official Report*, Commons, 31/1/11; col. 605.]

Those are good intentions. The Secretary of State gave voice to a noble purpose. However, what happened next was utterly predictable. The groundwork for these very important reforms was not properly laid by Ministers, and it probably was not helped when the Secretary of State told the House of Commons that he could do these reforms without this legislation at all. The legislation certainly contradicted the coalition agreement, so the arguments for reform barely got off the ground before they were shot down by internal arguments inside the coalition. I am afraid that politics rather than policy prevailed. Today we have again had a demonstration of an iron law of government: good intentions do not always result in good legislation.

In my experience, the Second Reading debate on any Bill is about the general principles. I am afraid that the longer this Bill has progressed, the harder it has become to discern what those principles are. Does the Bill favour or hinder localism? I think that it probably hinders it. The national Commissioning Board is a dramatic centralisation of power. Does the Bill represent an attack on bureaucracy? I think not. There seem to be even more layers of management. Some of the bodies coming into existence are the clinical commissioning groups, the clusters, the clinical senates and the well-being health boards, and sitting on top of all these is this new quango, the national Commissioning Board. I am sure the Minister knows that there is enormous upheaval going on in the NHS at the moment, and enormous uncertainty. Given the scale of the current challenge, I do not think that any of this is helpful.

What about promoting competition? I am in favour of that as long as it is properly managed. There is demonstrable research evidence showing that the introduction of new providers and new ideas in recent times in the NHS has improved the health of the poorest at a faster rate. I saw that in my own constituency and that was my experience over seven years as a Minister in the Department of Health. Competition can make the NHS more equitable. So, on this, I am afraid that I part company with some of my noble friends. I do not believe that competition is necessarily bad for the NHS, and I do not share the prophecy of doom that I have heard today. It is all about setting the proper ground rules. Are they being set properly? As I understand it, the amendments made to Monitor's duties in the House of Commons were designed largely to camouflage the political wheeler-dealing that went on behind the scenes. Are the changes to Monitor's duties significant? We have not the faintest idea, and we need to know. It is an extremely unsatisfactory situation.

So, any sense of direction and principle has largely been sacrificed. What the Bill stands for now depends very much on which Minister you talk to. It started out as a revolution, but the R was deleted in Committee in the House of Commons. We have ended up with some very obscure concessions whose significance is far from clear. The NHS needs clarity.

I strongly support, as I always did when I was a Minister, a greater role for clinicians in commissioning healthcare. There can be real advantages for NHS patients if we can get that right. However, I doubt that the proposals in the Bill represent the best and most effective way of doing it.

The White Paper rapidly became a white elephant, and now all we hear is white noise. That is a great shame. It has set back the case for the real reforms that the NHS needs today. It needs more enterprise and the stimulus that new providers can bring, but I am not sure that it will get that. It needs less centralisation; instead, it is getting the biggest quango that we have ever created in parliamentary terms. It needs less bureaucracy; I think that it will get the opposite of that. I do not think that the Bill moves any of the important principles of NHS reform sufficiently forward. Ministers have only themselves to blame for the situation they find themselves in.

However, I shall not be voting for the amendment of my noble friend Lord Rea. I do not believe that it is the duty of this House to form a view about whether a Bill has democratic legitimacy; that is very much the view of the House of Commons. It is they who eventually have that rendezvous with the electorate. They have to account for themselves and how they have run the country, we do not. So the Bill should have a Second Reading. The challenge for us is how we can best improve it. That is why I shall support the amendment of the noble Lords, Lord Owen and Lord Hennessy. It has been a distraction from that argument for some noble Lords to have said today that that amendment would represent some delay to or obfuscation of the Bill, which is not a fair interpretation of it. We can look to improve the Bill. My objective is to improve it, not to delay it. The Government have a mandate and are entitled to their legislation.

The stakes are very high. The case for principled reform remains important. That is not being helped by the way in which this Bill has been presented, amended and brought before us today.

5.52 pm

Lord Marks of Henley-on-Thames: My Lords, I agree with other noble Lords who have expressed the view that the Bill has been transformed during the pause. We should now welcome it in principle as offering a secure future for the National Health Service in the face of ever increasing demand, as defining a clear but decentralised structure, as making great progress in integrating health and social care, and as concentrating decision-making about patient care in the hands of clinicians and patients, where it should be.

[Lord Marks of Henley-on-Thames]

However, the Bill needs further improvement. In particular, perhaps I, too, may say a few words about the duties of the Secretary of State, especially in view of the very wide currency given to the published legal opinions obtained by 38 Degrees and in view of the report of your Lordships' Constitution Committee and the Government's recent response to it. I welcome the indication from my noble friend the Minister this morning regarding flexibility in this area, which seemed strangely at odds with his letter to the noble Baroness, Lady Jay, last night.

Although much of the strictly legal analysis of 38 Degrees' counsel stands up, his implied conclusions on the political effect of his advice are overstated. The Bill does not threaten the notion of a National Health Service, nor does it deprive the Secretary of State of the ultimate responsibility for the NHS—particularly with regard to three features of the Bill's proposals: first, the annual mandate to the Commissioning Board; secondly, the power to make regulations, the "standing rules"; and, thirdly, the power to intervene in the event of "significant failure" by the board or Monitor.

It is true that the duties of the Secretary of State are altered and that a duty to promote a comprehensive health service does not amount to a duty to provide services directly, but it is also true that direct provision has not been the practice for many years. Moreover, the Bill is a strongly decentralising measure—indeed, that is one of its best features—and you would expect such a change. However, a duty,

"to secure that services are provided",

remains in the Bill and, in my judgment, is no less potent than the duty in the 2006 Act to "secure the provision" of services. The problem with the proposed duty is that it is to be performed,

"in accordance with this Act",

and that includes, "in accordance with the duty to promote autonomy".

It is the "duty to promote autonomy" provisions which are my principal concern. Promoting autonomy is of course good. As the noble Baronesses, Lady Bottomley and Lady Williams—in their different ways—and others pointed out, the Secretary of State should avoid micromanagement and generally allow the board, commissioning bodies and Monitor to get on with their jobs. However, the autonomy provisions weaken the force of the duty to secure that services are provided, because they would make a failure by the Secretary of State or the board to intervene very difficult to challenge by judicial review except in an extreme case. Generally, the Secretary of State could simply defend himself against any challenge by pointing to his duty to promote autonomy. That is why 38 Degrees' counsel calls this a "hands off" clause.

In this I regret that I cannot agree with the passage in my noble friend's letter to the noble Baroness, Lady Jay, which states:

"The duty of autonomy will never prevent the Secretary of State intervening in the interests of the health service".

I fear that it could. Deleting the two duties to promote autonomy would not materially weaken the Bill or do violence to its intention, because the Bill's very structure builds in decentralisation and autonomy. I hope that the Government will in due course accept the force of these concerns and rebalance the structure proposed in the Bill accordingly.

Perhaps I may mention two further possible improvements to the Bill. The first concerns the regulations, or standing rules. As drafted, the Bill is unclear as to whether it is mandatory to make such regulations. One subsection of Clause 17 suggests that they must be made, while others do not. The standing rules will be of great importance. I therefore suggest that provision be made that regulations should be made at specified intervals and, further, that Parliament should have the extra opportunity of scrutinising the draft regulations by their being referred to the Health Committee for advance consideration before they are laid before Parliament as a whole.

The second point is that the Bill removes the powers in Sections 7 and 8 of the 2006 Act for the Secretary of State to give specific directions to individual bodies within the NHS. What remains is a power to intervene in the case of significant failure by the Commissioning Board or by Monitor, each of which has wide powers of intervention. I am concerned that the bar may be set too high against the Secretary of State's intervention, because in each case the significant failure concerned has to amount to a failure by the board or by Monitor to perform its functions at all or, at any rate, to perform them properly. Failure to perform them in a way that the Secretary of State considers to be in the interests of the NHS would not be enough. I regard that as an important lacuna. Some amendment of those provisions, too, would be a welcome improvement.

In the Third Reading debate in the other place, the Minister, my honourable friend Mr Paul Burstow, undertook,

"to offer clarification or make amendments to put beyond legal doubt the fact that the Secretary of State remains responsible and accountable for the comprehensive health service that we all want to see".—[*Official Report*, Commons, 7/9/11; col. 404.]

It is now for your Lordships' House to ensure that that aim will be achieved.

6 pm

Lord Williamson of Horton: My Lords, we all have a profound interest in our national universal health service, which in my view is one of our national treasures. This interest is demonstrated today by the very large number of letters that we have received and by the number of speeches in the debate. I shall try to restrict my comments to a limited number of points because evidently this package of 720 pages—that is to say, a Bill of 445 pages and an explanatory note of 275 pages, which are often difficult to comprehend—is likely to have a long life in Committee, where it requires, and will no doubt receive, detailed examination.

The first main question to the Minister is not about what is being proposed—although that is evidently important—but why is it being proposed? In short, why are the Government considering so substantially revising the current system, in particular the strategic health authorities, the primary care trust—which are now to be abolished under Clauses 30 and 31 of the Bill—the whole current provision of health services generally and the administration of hospitals? Obviously

improvements in the National Health Service are highly desirable. We have them all the time, in terms of medical knowledge and patient care.

I know that the Minister dealt with the reasoning. However, he was somewhat overwhelmed by the myriad changes to which he had to refer that, perhaps in winding up he will have another try at telling us why such a massive change is to be made, bearing in mind that changes on this scale are bound to cause some disruption and possibly an adverse effect on the morale of the people who really matter—that is to say, doctors, nurses, healthcare assistants, social workers and all the people who comprise the system of care for the whole nation. However, because the Bills' proposals are so large, I put it back to the Minister in the words of Tom Jones: "Why, why, why, Delilah?"—which I am unfortunately not allowed to sing here. This is my first question.

In addition to the basic question—why are we having all these changes?—I would like the Minister to respond to three points that I have selected either from recent parliamentary discussion or from the 445 pages of the Bill. From recent discussions, I ask what has happened to the practical steps for improving the services to patients that were presented to the House by the noble Lord, Lord Darzi, towards the end of the period of office of the previous Government. If I recall rightly, these included the possibility of strengthening patients' services through the establishment, particularly in some inner cities, of GP clinics that would provide a wider range of services at one site—for example, radiology, nursing and physiotherapy—which could have the effect of reducing the overload on hospital A&E services. This system works well in some countries.

Evidently, there are many people in Britain, particularly in the inner cities, who look to the A&E services as the first point of call if they have a health problem. The result is an inevitable overload. In the medium term, do the Government support the proposals of the noble Lord, Lord Darzi? Secondly, have the Government a view on the possibility of establishing more separate specialist units to deal, for example, with the limited number of major health conditions associated with the ageing population, thus also reducing the potential blocking of beds in general hospitals? It might be effective and good for patient confidence for such persons to look to dedicated units or clinics of which we do not have very many at the present time.

From the text of the Bill, I make one major point. The clinical commissioning groups, which are not necessarily large groups—we are told there may be 300 or 450, we simply do not know—are none the less the bedrock of the new system. There really is concern about how in practice they will be able to assess and provide for, to quote the Bill,

"such services and facilities as it considers appropriate for the purposes of the health service that relate to securing improvement… in the physical and mental health of the persons for whom it has responsibility, or… in the prevention, diagnosis and treatment of illness in those persons".

I am quite sure that there will be good will, but can this task be easily done at the level of, for example, a single large GP practice?

We do not know the size of these clinical commissioning groups, how much advice they will get or how they will operate on the ground. After all, the members of these clinical commissioning groups—at least, the clinicians—have to care for their own patients as well as having an enormous number of duties that are cited in the Bill in Clause 23—"effectiveness", "efficiency", "improvement in quality of services", "reducing inequalities", involving each patient, giving "patient choice", obtaining "appropriate advice", promoting "innovation", "research", "integration" and the NHS constitution. These all relate to the clinical commissioning groups. They may relate to others as well, but in the Bill they also relate to them. Is it fully workable? Will the Minister comment on the workability of these desirable objectives all at once at this basic level?

On the why and workability, I have some concerns. As an independent and always open-minded Cross-Bencher—as the Minister knows—I come to two points that I welcome. First, it is indispensable as the population ages and medicine becomes more complex to ensure the most efficient integration of medical and social care. There is room for improvements. For many patients, it is the most important element of their health, mobility and daily living problems. Therefore, I note with satisfaction that Clauses 191 and 192 of the Bill establish the health and well-being boards, which must encourage persons who arrange for the provision of any health or social care services to work in an integrated manner and to provide advice, assistance or other support. This is good.

In view of my long-standing interest in mental health, my final point is to welcome Clause 40, which makes local social service authorities responsible in relation to independent mental health advocates and inserts a provision into the Mental Health Act 1983,

"making arrangements to enable mental health advocates to be available to help qualifying patients".

This is also an improvement.

6.07 pm

Viscount Simon: My Lords, there continues to be too much reliance on market forces, pitching primary care against secondary care, damaging both as a consequence, while not recognising the existing strengths of primary care in providing a generalist service and secondary care in providing a specialist service. The Government seem to think that a specialist service can be provided by both. I suggest that this is wrong.

From all of the e-mails and correspondence that we have received, it appears that the continuing merry-go-round of bureaucracy, new legislation and reorganisation is damaging morale within the NHS. Not even senior doctors and managers are able to keep up with the changes. I wonder whether that is the intention of the Government. The Minister said that one of the intentions of the Bill was to depoliticise the NHS. If the Government are concerned about depoliticising the NHS, how come they have appointed police commissioners, which introduces a political element into the police? The two items of course are completely different, but they do not add up.

The words "any qualified provider" have appeared; these include private companies that will be able to provide services in the future, thereby draining resources from both primary and secondary care, cherry-picking

[Viscount Simon]
the low-risk cases without having to fund the technology or expertise of the more complex cases, or indeed the training and educating of doctors and nurses of the future. A few years ago, I was a member of the Select Committee looking into the provision of allergy services. We visited a number of places. One of them was Addenbrooke's Hospital in Cambridge. This unit is regarded as the country's leading allergy unit. I understand that it has been informed by the local commissioners that under the new Bill they are under no obligation to fund allergy services in Cambridge. That will threaten the very survival of this leading unit which treats patients from near and far and trains doctors to become specialised in allergic conditions, which are exceedingly complex. Is this in anticipation of what the commissioners consider the Bill will require? The noble Lord, Lord Kakkar, said that he is concerned with the future training of doctors and nurses and, with the potential closing of this very specialised unit, I agree with him.

Further, a neurosurgeon at Addenbrooke's recently told me that, due to the financial cuts, eight of his beds had been closed. How will patients with serious problems view this restriction? Could these be regarded as examples of the direction in which the NHS will go under the Bill?

The noble Lord, Lord Clement-Jones, said that the cuts already in place are not understood. In view of what is and might be happening at Addenbrooke's Hospital—and, I suspect, other hospitals—I am not surprised that patients, let alone health professionals, do not understand what is happening.

Finally, in order to have an example of one of the e-mails that we have all received on the official record, I would like to quote one from Mr Russell, which is short and to the point. He writes:

"Please do all in your power to prevent this awful bill from going through. We didn't vote for this level of change—it really should have been in a manifesto if the NHS is to be less accountable more bureaucratic and effectively partially privatised".

6.11 pm

The Countess of Mar: My Lords, like most noble Lords who have spoken or will be speaking, I am concerned about some of the contents of this Bill. I acknowledge the Government's good intentions but believe that they should, perhaps, consider a little more carefully where their good intentions might lead them.

I intend to concentrate on Clause 8, which deals with the Secretary of State's duties as regards the protection of public health, and to voice my concerns about the proposals for HealthWatch. Other noble Lords far more qualified than I am have dealt and will deal with the more complex matters. I remind the House that I am chairman of Forward-ME, a loose alliance of CFS/ME charities, and patron of several charities which care for people with ME or are funding research into the illness. I also suffer from the chronic effects resulting from sheep dip poisoning.

As has already been said, I believe that the Secretary of State must take the steps listed in Clause 8, which inserts new Section 2A into the National Health Service Act 2006. It is highly unlikely but possible for him or his successors to ease themselves out of what are recognised to be very important functions because they are not obliged by law to undertake them. I am sure that the noble Earl cannot have failed to notice my frustration when I have been trying to get what I consider to be very reasonable recognition and treatment for people with myalgic encephalomyelitis or CFS/ME—sheep farmers and farm workers who are ill as a result of being exposed to organophosphates, and Gulf War veterans—only to find that no one is ultimately responsible for ensuring that they receive adequate medical treatment. It is the "Not me guv" syndrome. I find it hard to believe that in 20 years of campaigning so little progress has been made.

That is particularly so with members of the CFS/ME community. They were delighted when, in 2002, the Chief Medical Officer arranged for £8.5 million to be ring-fenced in order for specialist centres to be set up regionally for the purposes of diagnosis and treatment of this illness. Some centres were established, but several have gradually disintegrated because the hospital trusts have withdrawn continued funding for appropriate staff. This has left many very sick people without recourse to inpatient treatment in a specialist centre since the ward at Queen's Hospital in Romford was recently closed, without daycare or, in some cases, without the continuing services of a GP. Perhaps most distressing is the dearth of provision for children who frequently become very ill because they have been pushed too hard in the early stages of their illness by people who do not understand ME.

If Her Majesty's Government are seeking to improve the lot of NHS patients, it is those who suffer chronic illnesses of currently unknown aetiology, who do not respond to standard drug or other treatments, who most deserve to be protected. I can think of no other group that is systematically discriminated against by the medical profession and social services. No other illness than ME has such a big impact on the lives of so many people and yet is given such limited funding for specialist care services and scientific research.

In desperation, frustration, or perhaps, egged on by periodic dramatic pronouncements from a small group of psychiatrists and eagerly taken up by the media supporting allegations of the spurious nature of this illness, medical practitioners and social workers too frequently resort to incarcerating adults in psychiatric hospitals under Section 3 of the Mental Health Act or, in the case of children, imposing child protection proceedings under the Children Act after accusing their parents of fabricated illness ideation. They are then subjected to treatment which I believe to be excessively harsh. When that fails, the patient is accused of failing to co-operate and is abandoned by the professions.

As the Minister knows, this is not fundamentally a psychiatric condition—there is an enormous amount of international, peer-reviewed research that points towards viral or environmental toxin causation, though it is not surprising that some patients show occasional signs of anxiety or depression as do sufferers from other chronic illnesses such as arthritis or cancer. Are they made to have cognitive behavioural therapy or graded exercises without any medical treatment? Why are the international consensus criteria published in

the *Journal of Internal Medicine* in July 2011, which laid out clearly the criteria for diagnosis of ME, and its predecessor, the Canadian criteria, rejected by NICE and the NHS?

ME is assumed to affect about a quarter of a million people in the UK. Some are mildly affected, some moderately affected and about 25 per cent are believed to be so seriously affected that they are housebound or even bedbound. There is no central register of cases so there is no accurate assessment of its prevalence. I suggest that this disease should be the responsibility of the NHS Commissioning Board to ensure that services are provided. ME would otherwise simply get lost in the sea of other much higher profile conditions such as cancer, diabetes and heart problems, which will dominate the allocation of resources by local commissioning groups.

There is a strong economic argument for ensuring that GPs can recognise and refer ME to clinics that can intervene early and mitigate the severity of the illness. This potentially reduces the levels of social care and welfare support required and, in time, should make huge net savings. A recent study by Simon M Collin et al, *The Impact of CFS/ME on Employment and Productivity in the UK,* showed that,

"each year 4.424 working age adults with CFS/ME might be referred for specialist assessment, and that this group would already have incurred productivity costs of £102.2 million due to their illness by the time of the assessment".

The researchers conclude:

"The main implication of our findings is that effects on employment and productivity must be accounted for in estimates of the cost-effectiveness of CFS/ME interventions and service provisions".

They make the point that many adults are not referred to specialist centres and that this financial estimate is very conservative. Indeed, earlier research by Sheffield Hallam University concluded that the total costs to the nation of CFS/ME exceed £3 billion when account is taken of the costs of healthcare, welfare support and social care in addition to lost earnings.

Simply looking at the economic aspects of the illness, it makes good sense to ensure early diagnosis. Research shows that early intervention by specialist teams will frequently prevent the illness becoming severe. There is clearly a need for joined-up thinking. Clause 12 inserts new Section 3B(3), which requires the Secretary of State to have regard to four key points. I think that I have made the case for ME to be an appropriate case for the board to prescribe services and facilities. It is time that the discrimination against these patients ended, and this Bill could provide just the vehicle.

I will not say much about my concerns about the proposals for HealthWatch at this stage, except to say that there should be a smooth transition from LINks and that it should be totally independent of local authorities and the Care Quality Commission. I know that noble Lords, including the noble Lord, Lord Patel, will be tabling amendments to that effect. Is the Minister aware that there is a long-standing charity of the same name? I fear that NHS patients may be confused and possibly disadvantaged. Can that conundrum be solved?

I do not believe that the House should reject the Bill outright at this stage. I am minded to support my noble friends in their Motion that part of the Bill should go to a Select Committee, but will wait until I hear what the noble Earl has to say before I make up my mind.

6.20 pm

Lord Haskel: My Lords, I cannot remember the last time I troubled your Lordships on health. There are so many others far better qualified than me to speak, but there are so many aspects to this Bill—nonclinical aspects—that I felt that I had to speak up.

My first concern is the Government's absolute failure to convince a reasonable proportion of the public of the need for the Bill. Yes, we have had a listening exercise; we have had the Future Forum; there has been debate and argument; yet the public remain confused and unconvinced of why the reforms are necessary. A decent analysis of why they are needed and what has gone wrong could win over the public, but it has not happened. I think that most of us in your Lordships' House would agree that, except in an emergency, forcing through legislation without convincing the public is usually both bad government and bad legislation—especially when, as my noble friends Lord Rea and Lady Thornton explained, the Government have no mandate.

Worse, the Bill ignores some of the lessons that we have recently learnt. I give a couple of examples. The Bill sets out to create a rather complicated structure of deals with the private sector to deliver some of our clinical services. We now know that the public service as presently organised is not set up effectively to manage such an arrangement. How do we know? We know because the Public Administration Select Committee has told us. So has the Institute for Government. So has the King's Fund and many others. They have all drawn our attention to the problems of additional complexity. The skills to oversee that sophisticated commissioning and contracting are just not there. According to the Select Committee, the Government are not responding to that. Indeed, cuts are leading to the loss of the very key skills required for the managerial complexity about which the noble Lord, Lord Darzi, spoke. Is the Minister listening and taking the necessary steps, or is he just hoping for the best?

We are told that all this will be regulated by Monitor—holding the ring, as the Minister put it. We now know that this kind of regulation does not always work, especially as the Bill does not lay down any licensing rules. In these days of dysfunctional markets, even regulated companies fail. Tighter regulation strangles competition. Loose regulation means that the public can be exploited. Get it wrong, and we know that the public will be the losers—in every way. We also know that we do not fully understand how to regulate this kind of market without it becoming permeated by the logic and interests of the participating businesses—all at the expense of the consumer and the benefit of the big players. For proof, I ask the Minister to look no further than the current situation in banking and at his next gas and electricity bills. That is why the public are becoming disillusioned with market solutions. I suspect that that is why the Government have been

[LORD HASKEL]
unable to have a meaningful dialogue with the public about the Bill. That is why I support the Motion of the noble Lord, Lord Owen, to send part of the Bill to a committee for further scrutiny. Let us take evidence and learn from recent experience.

You would have thought that with those problems of administration and regulation—problems central to the success of the Bill—a responsible Government would not implement change unless they were sure that they had all the tools, levers and skills in place. It is surely a mark of irresponsibility to do otherwise. Is there a crisis requiring urgent action? No. Does all this haste suggest that things are bad in the NHS? No. So why, as the noble Lord, Lord Williamson, asked? In 2001, 39 per cent of the public was satisfied or quite satisfied with the NHS. In 2009, that figure was 64 per cent. Those figures suggest that the task is not reform but to build on what is good. Surely, that is how to satisfy the rising demand, expectation and cost about which the Minister told us.

It is not as if now is an opportunity to be taken for reform. On the contrary: this is exactly the wrong time. The current Budget settlement requires the NHS to make year-on-year efficiency gains of 4 per cent for the next four years, yet the Government insist that spending on the NHS will increase by 3 per cent per year. No wonder NHS managers—to say nothing of the rest of us—are confused and worried about the lack of clarity and transparency in NHS finances.

In my other life, I spent 30 years building up a business, but it did not take me that long to learn that the discouragement and disarray presented by mixed objectives, confused budgeting or not carrying the staff with you meant that no objective was properly and fully achieved. As others have pointed out, it is also unclear who is in charge and who is accountable.

All of that is a sign of poor leadership and poor management by the Government: the kind of management that burns through money before you even know it has gone. We all know that, irrespective of whether we have had a life inside or outside of politics. I am sure that the Minister knows it as well.

Having demonstrated that this is a bad Bill, what should a competent and responsible Government do? With no mandate for radical change, it seems to me that the Government should be concentrating on incremental change to streamline and improve the performance of the NHS. The Secretary of State himself said that 90 per cent of what he wanted was possible in the existing structure.

I hesitate to trespass on clinicians' ground, but we have all received authoritative briefing about obliging clinicians and nurses to follow best treatment guidelines; the huge concern about mental illness; the need to be a lot more active in improving public health by insisting on standards for healthier food; avoiding the need for medical treatment caused by passive smoking or the violence and injury that alcohol causes, by more responsible marketing that does not target children or glamorise consumption. The Government have an important role in giving leadership in all those areas. Indeed, the Minister himself was very positive about that when he responded to the debate on this very topic last Thursday, especially when a noble Lord suggested that it was that that could overwhelm the NHS.

I remind the House that one of the legacy promises attached to London's bid for the Olympic Games was that, through the National Health Service, 1 million extra people would be taking more exercise every week. That was a promise made on the grounds that that would radically improve the nation's health. Press reports say that that has been quietly dropped. Is that true?

This is an important Bill. Our task in your Lordships' House is not political point-scoring; it is to bring our experience to bear. I have tried to show that mine tells me that this is a bad Bill: badly thought through and badly timed. In an ideal world, Second Reading would be quietly dropped, perhaps like the Olympic health legacy. By convention in this House we do not vote down Bills at Second Reading, but on this occasion I shall be supporting my noble friend Lord Rea so that we can devote our time to far more pressing and difficult matters.

6.30 pm

Lord Tugendhat: My Lords, I declare an interest as chairman of the Imperial College Healthcare NHS Trust. I begin by paying tribute to the staff of the NHS. They have had to respond to a bewildering set of changes, of direction, of organisational structures and of objectives during the past 15 months. All have played their part in keeping the show on the road but a particular word of praise should go to the managerial staff who are so often and so unfairly traduced in this House and indeed in the other place. It is they who are at the greatest risk of having their jobs merged or cut and it is they who are having to bear the particular burden of implementing some of the changes, many of which are caught somewhere between their departure point and their destination. Those staff deserve a considerable vote of confidence.

I speak as someone who is in favour of change in the NHS. Indeed, I have done my bit to promote it. I chaired the steering committee that brought about the merger of the former Hammersmith Hospitals Trust and the St Mary's Hospital Trust to create the Imperial College Healthcare Trust, which is one of the largest in the country. I have also been deeply involved in the creation of the Academic Health Science Centre, which comprises my trust and Imperial College. It is one of only five academic health science centres in the country and one of the most exciting innovations to have occurred in the National Health Service for a very long time.

I give that background because I want it to be clear that when I say that the Government were unwise to introduce the Bill, I am not against change—far from it. I support much of what the Government are trying to achieve: enhancing patient choice, foundation trust hospitals, the reduction in administrative structures, more efficient decision-making, the reconfiguration of services, more use, where appropriate, of private providers and more involvement of general practitioners in commissioning. I could go on. I do not agree with everything in the Bill by any means but I agree with a great deal of it.

The Government's mistake was to introduce a Bill that sought to impose a massive programme of management and structural change on top of an ambitious cost-cutting programme. I refer, of course, to what is now known as the Nicholson challenge—to make efficiency savings of £20 billion between 2011 and 2014. As many noble Lords will know, that is quite unprecedented and in itself is a huge and effective agent of change. The achievement of the Nicholson challenge is also of considerable importance to the Government's economic policy. In my view, the Government should have used the Nicholson challenge as their great engine of change. They should also have recognised that much of what they wish to achieve in relation to patient choice, FT hospitals, service reconfiguration, private providers and involving GPs in commissioning, could, as other noble Lords have pointed out, have been achieved by building on what the previous Government had done with little or no recourse to primary legislation. If the Government had proceeded in that way and been more selective in their objectives, they could have achieved more, to the practical benefit of the NHS, of patients and of their own economic policy. They could also have avoided what can only be described as a haemorrhage of political capital.

So what is to be done? In my opinion, at this stage there can be no going back. There has been too much change already, too many administrative structures have been dissolved and are in the process of being reformed, and too many objectives and policies are uncertain and in a state of flux. The eggs have been broken but the omelette has not been made. Although the Bill is in need of a good deal of improvement and will no doubt, rightly, be subjected to a good deal of amendment, the National Health Service needs closure. It needs the stability that only the statute book can provide. I therefore urge noble Lords to reject the amendment in the names of the noble Lords, Lord Owen and Lord Hennessy. I understand what lies behind it and the advantages that they seek, but the NHS now requires closure and stability. I am struck by the fact that other noble Lords who are themselves directly involved in the NHS all appear to share this view.

In the time allotted to me, I cannot deal with many of the big issues already raised in this debate. Rather than touch on several in an inadequate fashion, I shall concentrate on one that I consider of critical importance. I refer to service reconfiguration, those slightly fancy words used to cover the rationalisation of services, their concentration on fewer sites and the scaling back of some hospitals. At present, there is too much duplication of services on too many sites. Too much is being done in hospitals that ought to be done in surgeries and at home. This is both needlessly costly and clinically unsound. There is a mass of evidence that shows that clinical standards improve if some specialist services are concentrated in bigger centres so that surgeons can perform complex operations more often and more regularly. The same applies not just to operations but to other treatments. This also facilitates investment in expensive state-of-the-art equipment. Likewise, modern medicine can often offer better care by getting patients out of hospitals and moving services into the community.

As we all know, it is hard to convince the general public of both those propositions. Shifting services from one site to another and scaling back hospitals, let alone closing them, causes acute local anguish and corresponding political protest. Of course it requires, and should require, extensive local consultation. My fear is that some of the new structures and procedures introduced in the Bill will make that consultation and those procedures even more complicated than they are at present—or, rather, than they were before the Bill was introduced. As a result, there is a big danger that the changes will not be undertaken on a planned and rational basis that takes due account of patient needs and clinical requirements; rather, they will be salami sliced in an ad hoc fashion in order to get around consultative procedures and to meet arbitrary deadlines.

The NHS is already under intense financial pressure that is bound to lead to some diminution of services. Ministers would do well to warn the country more loudly than they have of what is in store. It is vital, though, that as far as possible—and it will not always be possible—financial requirements should go with rather than against the grain of patient needs and clinical priorities. With that in mind, I hope that the Government will give serious consideration to a proposal from the King's Fund, designed to depoliticise this process as far as possible. The proposal is that instead of the Secretary of State, the Independent Reconfiguration Panel should act as the final arbiter on reconfiguration proposals. I think that the King's Fund is right when it argues that this would make the process more transparent and send a strong message to the local level that political considerations would not be the deciding factor, as they have so often been in the past. I believe, too, that this would speed up the process, which would be in the interest of clinical priorities and of meeting the Nicholson challenge. It would also be in line with the argument, in *Liberating the NHS*, that the Secretary of State should concern himself less with operational detail and more with strategic direction.

6.40 pm

Baroness Wilkins: My Lords, I am delighted to follow the noble Lord, Lord Tugendhat, since I received the help of the excellent district nurses in his trust, for which I am grateful. I stress yet again the volume of concern that has been expressed about this Bill and that has just been so ably expressed by the noble Lord, Lord Haskel. I trust noble Lords will not ignore the fact that the public are deeply fearful about the Government's plans for their health service, and that they are relying on this House to protect it.

Knowing the number of speakers today, I decided to be brief and concentrate on just one issue—the co-ordination of services for children. I am grateful to the Every Disabled Child Matters campaign and the Communication Trust for their help. There are around 770,000 disabled children living in the UK, a number that will increase in the future as medical advances ensure that more children survive birth and childhood illness. To succeed in life a disabled child and their parents and carers need help and support, not only to identify their support needs but to overcome any problems that arise. This requires partnership working

[Baroness Wilkins]
across health, social care and education boundaries. The current system is already a difficult maze to negotiate for parents seeking support. If the changes go ahead, I fear that it will become even harder.

While health and well-being boards will be charged with co-ordinating the planning and delivery of health, social care and public health services at a local level, there will be no place at their table for education providers. However, experience tells us that the most effective interventions are often those delivered in non-health settings such as a school or children's centre. We are already seeing some PCTs altering their structures in anticipation of a reformed health system to pilot new programmes. However, there has been no guidance on how children's health services will be commissioned and delivered. It is sadly typical; children and young people are forgotten again in a health and social care system designed for adults. Worse still, the Education Bill, currently before your Lordships' House, will remove the duty on schools, academies and colleges to co-operate. As has happened so often in the past, where agencies are not required to work together there will be a loosening of ties. A government policy of simply hoping that co-operation will happen is no guarantee that it will, whatever the Government's warm words, and it is disabled children who will miss out.

What, then, about the welcome proposals in the Department for Education's recent Green Paper? It suggests new approaches to special educational needs and disability and calls for more co-ordination: a single assessment process, a joint education, health and care plan and a local offer, all of which will set out the services available to a disabled child in a local area. I fear that it will remain an unmet aspiration as energy and money are devoted to tearing up current systems and installing new structures, new acronyms and new titles—all of which are expected to work within a reduced budget.

Take, for example, the commissioning of speech and language services for children with speech, language and communication needs. One child in 10 has a speech and language difficulty. It is the most common disability in childhood and the most common type of primary need for pupils with special educational need statements. Unaddressed, issues with a child's speech, language and communication needs risk problems with literacy, numeracy and learning as they move through the education system. Just 20 per cent of children with these problems achieve the expected level in maths and English at the end of primary school, compared with 72 per cent of all children. Needless to say, the gap widens even more by the end of secondary school. However, as Sarah Teather, the Minister for Children, admitted earlier this year, the chance of a child with speech, language and communication needs now receiving speech and language therapy is between low and nil. How will tearing up the current system enhance the chance of a child with speech and language problems receiving adequate help—help that is best delivered by co-ordination between health and education services?

I remain deeply concerned that while we spend time debating more changes, and more time, energy and money are spent on designing new systems rather than simply making the current structure work better, once again it is the needs of disabled children that will be forgotten.

6.45 pm

Lord Greaves: My Lords, I declare an interest as a member of a local authority and, like everybody else, a patient—or perhaps a consumer of NHS services. I worked out that I would certainly have been dead at least three times if it had not been for the NHS at various times in my life. No doubt other noble Lords are in the same state—that is, we are alive and well and thriving, despite that. We have heard a wealth of detailed knowledge and experience, although we are not yet half way through this astonishing debate. I have had at least one e-mail this afternoon from somebody who has been watching and listening to the debate and commenting on it. Perhaps all noble Lords will get that when they get back to their computers. I associate myself particularly with many of the remarks made, particularly those of my noble friends Lady Jolly, Lady Williams of Crosby and Lord Marks of Henley-on-Thames.

I shall make several general remarks that put the Bill into a wider political context. If it gets a Second Reading, as I expect it will, I shall hope to take part in the Committee stage on areas where I perhaps have something to contribute and that relate to local structures, the role of local government, the complexity of the proposed structures and systems and how we can sort them out a little, and the representation of the interests of patients and citizens.

As we know, the debate in the country on the Bill is extremely polarised. People often ask me about my work as a Member of your Lordships' House and we end up having a fairly complicated discussion about what we do and how we do it; I do not know whether they are impressed. This Bill is different. People simply say, "Will you vote for it or against it?". There is a lack of understanding of many of the changes that have already been made to the Bill. It would help the process of improving the Bill if many of the campaigners and the Opposition would recognise the genuine progress that was made before it came here. A great deal of that progress resulted from action taken by the Liberal Democrat party conference in Sheffield in the spring, the pause that was a direct result of it and the changes that came from that. Unless we understand what the Bill was like when it started and how it changed in the House of Commons—there were allegedly 1,000 amendments—we will not understand how it comes to be what it is now and what we can do to improve it further.

Some of the changes that have been made include the fact that competition can now be on the basis only of quality and not of price. That is a great improvement on the legacy of the Labour Government. Commissioning groups will be more accountable, involving the health and well-being boards in their decisions. These commissioning consortia will meet in public and publish all their plans in draft form for public consultation. That is a significant improvement in local accountability. We are told that there will be no more cherry picking of easy, profitable services by new private providers.

Along with all these things, that is something that we shall want to probe. There is no doubt that, despite the House of Commons having spent a very long time debating the Bill, the changes at the end were all put through in two days. Many of them were not properly debated at that stage. If the Bill gets a Second Reading here, one of the jobs that this House must do is to look at those changes, understand them and see whether they will work or need fettling a little more.

NHS commissioning is to remain a public function in full compliance with the Human Rights Act and Freedom of Information laws. That is very important. Commissioning decisions are not to be outsourced to private companies; they have to be made by the commissioning consortium. That is also very important, and something that a lot of people have been concerned about. Monitor will have a primary duty to promote patients' interests. There is a big debate still to be had about its role in relation to competition, but it is no longer to promote competition; it is to prevent anti-competitive behaviour. I am sure your Lordships will want to scrutinise what that means. There have been huge improvements. Unless we understand them and the role of the Liberal Democrats in achieving them, we will not get as far as we should.

Is the job done? No, it is not. It is part-done and if the Bill is to remain, there is a great deal more to do. Should we give it a Second Reading and scrutinise it in detail, improve it by debate, negotiation and if necessary Division, in the normal way in which the House of Lords works? If we are going to do that it is vital that it is given enough time. The intention is for it to have 10 days in Committee. There are days and there are days, as we have seen with the Localism Bill. Some days can be half an hour, and others can be a full day. Ten days are not enough, and the Government would not be right to push this through as quickly as possible. If the House is going to do its job properly, it has to be given the time and the resources to do it.

The letter sent by the Minister, the noble Earl, Lord Howe, said that the House must have proper time to examine the Bill. He also said that it should be done expeditiously. The relationships between the two Front Benches in this House have not always been the best during this Session of Parliament, but like other noble Lords I was impressed by the Minister's presentation and that of the noble Baroness, Lady Thornton, who, if I understood her correctly, promised that the Labour Party would not delay for delay's sake but would seek to scrutinise the Bill properly. If that happens and there are good relationships around the House, the job can be done well.

What is the case for supporting the amendment from the noble Lord, Lord Rea? It is that if this Bill is passed it will be forced through in the face of massive opposition and concern within the health service. This is the fault of the Government, perhaps of a gung-ho Secretary of State and certainly of the language used. As I think the noble Lord, Lord Warner, said, you listen to different Ministers and still get a different message. Some of the concern is certainly justified, some may be a result of misunderstanding, and some is possibly deliberate misrepresentation. We attack the views of so many professionals at our peril. They cannot all be wrong.

The Bill will be forced through in the face of massive concerns from the public, and those of us on these Benches ought to be aware of the massive concerns among Liberal Democrat voters in particular. Opinion polls are not too reliable on this kind of thing, but it is clear that there is no settled consensus in the country behind these reforms. The Government have lost the argument in the country and in the NHS. The noble Lord, Lord Tugendhat, said that it is a haemorrhage of political capital. I would say that they have lost the plot. It will be very difficult indeed to get the argument in the country back on to a reasonable level and away from, "Are you against wrecking the NHS?", which is the argument at the moment.

What is the best way of doing this? We can vote for the Bill to have its Second Reading, as I suspect we will, and we can scrutinise it properly, and I will certainly take my full part in that; or we can refuse to give it a Second Reading, tell the Government to go back and sort out the reorganisation of the NHS that is taking place in a semi-botched way as the Bill casts its shadow before it—this can be done without further legislation—and concentrate on sorting out the 4 per cent efficiency cuts. I am minded to support the amendment in the name of the noble Lord, Lord Rea, if it is put to the vote, but I shall continue to listen to the debate before that vote takes place.

6.54 pm

Baroness Hollins: My Lords, I worked in the NHS for 40 years, initially as a GP but for 30 years as a consultant clinical and academic psychiatrist, and of course I know that change and development are constantly needed to improve everyone's health and well-being. I must admit, though, as a survivor of many top-down NHS reforms, that I favour incremental reform.

As a past president of the Royal College of Psychiatrists, I have been talking to the college and mental health charities regarding the Bill. I and they recognise many positive elements in it, in particular the proposed strengthening of clinical leadership and the focus on clinical outcomes and the interests of patients.

I want to make five points today. My first point is a question. Is there is a need for legislation at all? Is the Bill needed to enable the Government to press forward with their key reforms? I put this question to the chief executive of the NHS last night. If the Bill were dropped, what would the legislative gaps be? He replied that there would be a lack of certainty in the direction of travel. This Bill seems to have generated its own uncertainty among health professionals in the NHS.

Let me share the results of an electronic survey conducted over the weekend of members of the Royal College of Psychiatrists working in England. I am afraid that it is not good news. A staggering 84 per cent of nearly 2,000 respondents—20 per cent of eligible members—are asking for the Bill to be withdrawn. Eighty-five per cent think that the Bill would result in a more fragmented system of healthcare, and 86 per cent said that the Bill would not decrease bureaucracy. Successful reform requires the confidence and buy-in of those who work in the NHS.

My second point is about how this Bill can best address mental and physical health needs together in the NHS. We know that it is often the neediest who are denied access to psychiatric and medical services. It is true that sometimes mental health service users and people with learning disabilities may be more difficult to engage with due to their illness or their ability, and

[Baroness Hollins]
that can require extra time and skill. Our patients and the health professionals who work with them often face the problem of stigma, which other health professionals do not usually have to deal with.

What can the Government do about this? I suggest that one way would be for them to strengthen the presence of mental health in the Bill. I am preparing some amendments to help this to happen and I do hope that the noble Earl the Minister will see the wisdom of my suggestions. Specifying physical and mental illness in the Bill instead of just illness would enable the Government to stand firmly by their stated intention in the mental health strategy to ensure parity of esteem for mental and physical illness, and to recognise that there is no health without mental health.

Mind you, there is a long way to go to ensure parity of provision. Twenty per cent of the disease burden in the United Kingdom is attributed to mental health problems, compared with only 16 per cent for cardiovascular disease and 16 per cent for cancer. Unfortunately, only 12 per cent of the available resources are currently allocated to mental health, and sadly this inequity includes a lack of adequate investment in specialist services and research. No other health condition matches mental ill health in the combined extent of its prevalence, persistence and breadth of impact.

However, mental and physical illnesses are not quite as different as is sometimes supposed. It is unsurprising, given that the brain and the heart are in the same body, that depression and heart disease are so closely related. But people who are already patients of mental health or learning disability services suffer terribly from diagnostic overshadowing. In other words, if they have a diagnosis of depression, all their symptoms may be attributed to the depression. Their physical illnesses just do not get the same attention. Likewise, those with a primary diagnosis of heart disease, diabetes or stroke often fail to get adequate psychiatric attention. The mind/body split, which has been made far too concrete in the separation of service providers and in simplistic attempts to define tariffs, has not served patients well.

There are some statistics that highlight how, with more enlightened clinically-led services, we will perhaps be able to save lives and money. For example, more than 40 per cent of smokers have a mental health problem; and let me stress that smoking did not cause their problem. Paying greater attention to treating mental health problems might be a cost-effective way to improve many more people's health and well-being.

My third point is about choice. Enhancing patient choice is not quite the right answer in mental health, unless by choice we mean involving service users in designing and managing their own care pathways. Indeed, choice is often rather a hollow concept in mental health services, with so many patients being treated against their will. Mental health services work closely with local GPs and other agencies in the community. Increasing choice for our patients could actually hamper access to an integrated and safe service, and to continuity of care—especially as these services are already about both health and social care, and the co-terminosity of providers is important. Increasing the presence of the service user's voice is much more important than choice, and the role of an independent HealthWatch could be key.

This brings me on to my fourth point, which is about introducing the new commissioning challenges at a time of austerity. I heard today from a senior psychiatrist about how the cuts are affecting direct patient care in his mental health trust, where 15 per cent of consultants are expected to leave in the next three years, and 10 per cent of community workers are to be lost in the next year.

For the first time, a health Bill has a very welcome clause about reducing health inequalities but there is doubt about whether the structures proposed will achieve this. The most significant concern emerging from mental health charities and the Academy of Medical Royal Colleges is that the Bill might actually increase health inequalities. I am sure that everyone in this House shares my wish to keep the NHS as a publicly funded service providing comprehensive care for the good of all the people. However, it is difficult to be optimistic about more positive outcomes being achieved through the new commissioning arrangements proposed for people with mental illness or people with learning disabilities.

Monitor's role will include setting the price for services once commissioning boards have defined what will be bought. However, in mental health there are real difficulties in defining population and individual need. There is already good evidence to show that joint strategic needs assessments are failing to understand the needs of people with mental illness or those with learning disabilities. Given the wish of the Government to give more responsibility to clinicians, we need to make sure that new commissioning bureaucracy does not get in the way of letting individual clinicians create collaborative, innovative pathways with inbuilt continuity in partnership with patients. I am not talking here about Monitor's duty to maintain organisational continuity but instead about the continuity of individual care pathways, which is exactly what is required for so many patients with serious mental illness or for people with learning disabilities who also have associated physical or mental health problems. I can see neither how the new commissioners will be able to acquire such expertise in the near future nor how Monitor will be able to develop appropriate pricing expertise in complex mental health and social care in order to avoid horrendous planning blight for the foreseeable future. My experience is that planning blight has impeded progress after every top-down reform and that mental health and learning disability services have never been at the top of the priority list to sort out.

My fifth and final point is about public health and the link with wealth inequality. When I was a child and first talked about wanting to be a doctor, my father told me that the greatest improvements in health in the 20th century were due to the efforts of the Victorian engineers who reduced the incidence of cholera by better drains. However, an analogy with a utility company such as water would be simplistic in the 21st century. The 21st century equivalent of better drains is better public services above ground. Some of these will be health services, but health services are not fully responsible

for preventing disease. A Government committed to rebalancing the current levels of wealth inequality that are bad for the whole population, not just disadvantaged groups, would achieve the greatest reduction in most chronic illnesses.

Most commentators talk of the NHS in terms of waiting lists but it is the management of chronic conditions that require continuity and flexibility that is more challenging. These are conditions that require people to stay in touch with specialist services for long periods of their lives. Such patients want a trusted local service, with in-patient beds for the times they get too ill to stay at home. This is not about shopping; it is about integrated personalised care.

7.05 pm

Baroness Howells of St Davids: My Lords, I decided today to bring to the attention of the House excerpts from the correspondence that I received from people who in the early days were invited by the British Government to come to Britain and serve in the National Health Service. They have taken the trouble—although most of them have retired—to write to me and ask if I would bring to the attention of the House the fact that the United Kingdom has been admired for its National Health Service that looks after the health of the nation. Those people remember that every Government thus far has seen it as a privilege to be the custodians of the NHS—and they are very proud of the part they played in that.

Despite what the Minister said in his opening speech, the letters suggest that if this Bill goes through in its present state it will reduce accountability to the Secretary of State and thereby to the taxpayers. The clause in the Bill relating to this has created many problems for the citizens of the UK, as has been said today. One of the anxieties is: to whom is the NHS accountable, if not through the Secretary of State to the electorate? I hope that the Minister will reply to this because it is a burning question for not just those who wrote to me, but nearly everyone in this Chamber who mentioned accountability.

As the Bill stands, there will be increased bureaucracy and costs, and—dare I say—potential legal challenge through the application of procurement law. Will the new and inexperienced commissioning consortia be the appropriate responsible bodies for dealing with these legal challenges? How will this improve the National Health Service, especially at this time when we have a downturn in the economy, squeezes in all areas of government, reductions in staff numbers and immense pressure on the confidence, well-being and mutual trust of staff and patients? The National Health Service is not about things. It is about people. People are different. There is still uncertainty as to the impact of competition law. It is very likely that competition law will apply to the NHS. Have the implications been properly considered? If not, the NHS will be subject to uncertainty and delay, and it will prompt access to legal action that will take away finances from the treatment of patients.

The NHS has often been described as world class because those who work in it have been considered by others as being the most dedicated public servants in the country. Other countries seek to learn from our comprehensive system of practice and its role as the medical home for patients needing continuity of care and co-ordination. The NHS's reputation has always had a focus on evidence-based medicine, supported by internationally respected clinical researchers; with the funding from the public purse it continues to impress worldwide. There is a great fear among these people that with later developments in other countries the citizens of the United Kingdom will not be able to depend on the National Health Service, which we always boast is free at the point of need.

There have been criticisms of the NHS by users and managers alike in the past. This Bill is meant to improve and enhance the NHS and to evaluate whether it is fit for purpose in the changing world. The Government have had two goes at this Bill and still the criticism comes aplenty in letters from clinicians, patient groups, individuals and trade unions. One of the letters I read was from a doctor who was trained in this country and worked for the National Health Service until he retired. He said he pleaded for my support to protect the founding principles of our National Health Service. He further suggested that the Bill has the potential to destroy the NHS as a universal service. It is very difficult to disagree with him after the other speakers I have heard today.

The Minister in his presentation said that responsibility was not taken away from the Secretary of State. I am afraid market competition and profit, not patient need, will drive the service if we accept the Bill as it is. Taking dentistry as an example, while we accept that competition can drive innovative services, how can it benefit ill people who are poor, illiterate and without internet access? This service as is proposed will cause more harm to patients than good. Those who live outside the radar of the healthy, the employed and the respectable will be sorely disadvantaged if this Bill is rushed through. Sick people need their local hospital or clinic to remain open and to provide comprehensive care. By introducing competition law this Bill has the potential to erode collaboration between primary and secondary care providers. It will not enhance it.

The Bill also has the potential to destabilise the training of doctors, nurses and ancillary healthcare workers. The number of illnesses far outweigh the service they can give because of the pressures on them. As has been said, this Bill has no electoral mandate. It further appears to flout open promises made by the Prime Minister not to engage in top-down reform. That is exactly what it is proposing. There is a sea of worry out there with good cause. Long-term illnesses will be driven into a US-style of healthcare which Professor Pollock describes as,

"islands of excellence in a sea of misery".

A well known political figure recently said the NHS as it stands is one of the most efficient, cheapest and fairest health systems in the world. Most practitioners and service users in the field of health and social care share a singular desire—the best possible future for the NHS—and this is not yet shown in this Bill. I ask on behalf of those who wrote to me that we re-examine the way this Bill will become law.

7.14 pm

Baroness Morgan of Drefelin: My Lords, this has been a powerful debate already and, as number 51 on the speakers list, I represent perhaps the move into the beginnings of the home straight for the Minister and all the winders. I have been particularly impressed by the contributions today and am very much convinced by the arguments for the amendment of the noble Lord, Lord Owen, not least because of my concerns about the issues around Monitor and the failure regime. Given the lateness of the amendments, there is a need to scrutinise that part of the Bill and perhaps hear evidence from those outside this Chamber.

I want to focus on three important areas that have not been touched on in much detail so far: research; commissioning, particularly for cancer patients; and patient involvement. For the record, I declare an interest as chief executive of the research charity Breast Cancer Campaign.

On research, we have already heard from the noble Lord, Lord Willis, that the role of medical and scientific research in the promotion of high-quality healthcare is extremely important and highly significant. I am delighted that I am not the only one who has highlighted research today. The noble Lord, Lord Darzi, also made a very important point. We should not forget that long-term improvements in treatments are largely derived from and are dependent upon medical research, which requires long-term investment. The NHS offers a unique setting in the world for research and has enormous potential to enable and support advances in research. My concern is that we are still far from maximising the potential for patient benefit.

I am pleased that the Government have responded positively to concerns about the future for research in the NHS by introducing duties to promote research, which will be placed on the Secretary of State and commissioning consortia alongside the existing duty on the Commissioning Board. The AMRC and other medical research charities, including my own, have campaigned for that. However, I will be pressing the Minister to provide further detail as to what these duties will mean in practice. As the noble Lord, Lord Willis, said earlier, we need to be very careful that these duties are not just window dressing. In particular, I want it to be clear that there should be measurable benchmarks developed as a result of these duties.

I, too, must raise the issue of the regulation and governance of medical research. The key report by the Academy of Medical Sciences on this subject has been widely welcomed and I look forward to hearing more from the Minister about a timetable for the further development of the Health Research Authority—I do not understand at all why this cannot be in this Bill. Surely there is a great opportunity here to get that right and establish the authority.

The same Academy of Medical Sciences report raised the need to simplify the use of NHS patient data. This is a really important opportunity for progress. Another example of the positive use of patient data is the million women study—a collaborative project among Cancer Research UK, the NHS and others that involves more than 1 million women aged 50 and over—which identified the cancer risks of hormone replacement therapy, which is a key issue for women in this country. Will the Minister explain what consideration he and his colleagues have given to taking action on patient data to ensure greater simplicity within the system in order to promote such vital research?

My second point is on commissioning. We have heard a lot about commissioning, but I want to focus particularly on the commissioning of cancer services. We know that improving outcomes in cancer can be promoted only by collaboration and by commissioning across primary, secondary and tertiary services and public health, taking into account the need for high-quality research, because we know that patients do better when they are part of clinical trials.

For example, radiotherapy is a service that needs to be co-ordinated at regional and national levels, as it requires large planning populations and has a significant capital cost to be considered. In a recent report by the Cancer Campaigning Group, 81 per cent of GPs surveyed said that they believed that radiotherapy should be commissioned at a regional or national level, but is this what is going to be proposed? I still do not fully understand that.

Another example is the commissioning of pathology, which I am also concerned about. This issue is close to my heart because Breast Cancer Campaign has established the UK's first tissue bank, which has been a huge endeavour. NHS pathologists have contributed to that, often in their own time, and have really gone the extra mile because they believed in making the project happen. How that will work going forward is of great concern. We rely on a lot of good will from NHS employees to make research possible in this country.

The Cancer Campaigning Group—whose membership includes over 50 charities, including Macmillan Cancer Support, the Prostate Cancer Charity and Cancer Research UK, which I have already mentioned—has argued very strongly for the vital role that cancer networks must play, which must be maintained. The Government have listened to these arguments and made funding available to fund and support cancer networks, which are a vital source of expertise and drive in promoting improved quality in cancer services, but that is only until 2013. I hope that the Minister will be able to set out how the Government intend to guarantee the best future for cancer networks going forward.

I know that there are implications for other disease areas, too. I would be particularly interested to hear the Minister's thoughts on how to ensure that networks receive sufficient funding, have the capacity to commission high-quality cancer care for patients at all stages of their cancer journey and have a suitable accountability structure. I would also like to hear about how their role can work in supporting patient involvement. I am happy for the Minister to write to me in response, because I have a feeling that he may have a lot of points to come on to later. We have all seen real improvements in cancer care in recent years in this country, which has been driven largely through collaboration and integration, and we need to understand how that can go forward.

In my last point, I want to say something quickly about patient involvement, which I believe is fundamental to improving the quality of care. "No decision about

me without me" sounds great, but I understand that the assessment of the Richmond Group of patient-led health charities is that this principle has not yet been fully adopted in the context of NHS service design and planning processes. To do that would mean that the duties on commissioning bodies and Monitor to obtain advice in discharging their functions should be further extended to more fully encompass patient involvement.

7.24 pm

Baroness Wheeler: My Lords, in this marathon of debates, I want to focus my attention on two of the key issues that I will be leading for on behalf of the Front Bench. These arise from Part 5 of the Bill, and it is clear from the debate so far that they are matters which will absorb much of your Lordships' attention in the coming weeks. First, I refer to the issue of how patients' voice and involvement can be truly embedded into the Bill, and, secondly, how we might ensure that the Bill promotes integration across the NHS, public health and community and social care and gives impetus and encouragement to the progress that has been made over the past few years, despite the difficulties and obstacles that can be faced joining services up to the benefit of patients and carers.

In the 15 September debate in your Lordships' House on the implementation of the Future Forum recommendations, which noble Lords variously described as an overture or limbering up for today, my noble friend Lady Pitkeathley described reflecting patients' voice in health and social care as,

"enabling disadvantaged individuals—clients, carers and patients—to speak up for themselves and to contribute to policy formation".—[*Official Report*, 15/9/11; col. 873.]

This sums up in a nutshell what must arguably be the major priority if the laudable aim of "no decision about me, without me" is to become a reality for the majority of patients and clients. The Future Forum underlined the importance for the voice of patients and the public to be embedded in our health services, including the voices of children, vulnerable adults, carers and those who are often excluded. In evidence to the House of Commons Select Committee on the reconvened Bill, the chief executive of the mental health charity Rethink, Paul Jenkins, supported the need to,

"put patients and carers on the same footing as specialist clinicians in terms of the requirement to seek advice, so the advice of expert patients is as important in some aspects of long-term conditions as that of clinicians".

We support that aim, which, along with harnessing the collective patient view of such organisations as Rethink or the Stroke Association, will be essential if services that are high quality and sustainable in the future are to be designed. We will seek changes in the public involvement provision in the Bill to place greater emphasis on the proactive involvement of public and patients before decisions are made. I would also ask how lessons in future are to be learnt from the mid-Staffs experience, where we know that this collective patient voice was ignored.

It is clear from the contributions in the debate today that there needs to be much discussion and development to define what patient involvement and shared decision-making actually means at each level, and that the Bill as currently constructed does not deal with or address these issues and is in effect woefully inadequate in embedding the patients' voice into the new structures. From these Benches we will table and support amendments to the Bill which strengthen the emphasis on patient and public involvement in the structures of all local bodies, including foundation trusts, clinical commissioning groups and health and well-being boards. We will aim to get the current loopholes and get-out provisions, for example in the requirement for these bodies to hold public meetings, well and truly plugged. Health commissioners and providers must operate under the same standards of good governance to which local authorities and other public bodies comply.

We will also support the proposals from key patient groups to define what the duty under Clauses 20 and 23 to promote the involvement of each patient means, and the specific aspects of involvement that commissioners should promote. We will seek specific proposals in the Bill to recognise expert patients, carers and patient organisations as people from whom commissioners should obtain advice. As the Patient Voice has said:

"It is about commissioning care and treatment services in such a way that those services engage patients as fully as possible in managing and controlling their health and care".

How will the NHS Commissioning Board and CCGs be held to account for promoting patient involvement?

We also support the need for the establishment in the Bill of a duty of candour for any organisation providing NHS and social care, so patients and clients can be informed when things go wrong with their care and treatment, as soon as it is known, not after months of denial, legal obfuscation and cover-up. This is a new area of development, and I ask the Minister if the Government would support the provision of such a duty.

Finally HealthWatch England must have the teeth, strength and independence to be an effective patient champion. We strongly support the principle of a national body representing patients, with local outposts, but running alongside other measures which ensure patients and public are directly involved in decision-making. We do not support HealthWatch England being a sub-committee of the Care Quality Commission, and will seek amendments to the Bill that delete this provision. We agree with members of the current Local Improvement Networks, LINks, that HealthWatch's role, work, independence and authority will be severely compromised if the proposed CQC relationship remains. Instead, HealthWatch's powers should be extended to enable it to make recommendations direct to the Secretary of State and to the various arm's-length bodies to which it relates. We will also be seeking to ensure that these bodies are required to respond publicly to HealthWatch. We will also seek to ensure that local HealthWatch organisations are properly resourced to undertake the important and key work that they will have.

Let me turn to the issue of integration of NHS public health and social care. In his written response to questions raised by me during the 15 September debate on the Future Forum's continuing role, and how its findings would be fed into the Bill, the Minister responded:

[Baroness Wheeler]

"The future work of the forum is focused on implementation of the Government's modernisation plans, and is therefore unlikely to require further amendments to the Bill".

So, no second pause, then. The forum has been asked to look at how to ensure that,

"the Government's modernisation programme leads to better integration of services around people's needs".

Good question. The forum will be asking where services should be better integrated around patients, service users and carers—both within the NHS and between the NHS and local government. I am pleased to note that they are particularly interested in social care examples, for example better management of long-term conditions, better care of older people, more effective handover of a person's care from one part of the system to another.

From these Benches we will be tabling and supporting amendments to provide for a definition of integration in the Bill so that it encompasses NHS, public health and social and community care. Given the Future Forum's continuation into what is becoming to look like a pretty permanent role, what better way than to provide a clear legislative framework, context and direction for the forum to work to?

There is much confusion about what is meant by integration, which needs to be addressed. Even the Prime Minister himself is confused, since one of his famous five pledges is on integration but relates primarily to NHS integration, not integration across health, public health and community and social care.

In practice, integration models in the NHS and social care are varied and diverse. You have provider integration in the NHS; commissioning integration across health and social care; structural integration across health and social care organisations, such as healthcare trusts; integrated pathways, which are mostly NHS focused but with some excellent examples across both systems, such as stroke and reablement; and finally, integration around individual patient users, such as personal budgets and direct payments.

We strongly support defining integration in the Bill to ensure that national policy promotes the supporting context for integration. Currently, health and local government are only required to "act in an integrated way". Both the excellent work undertaken, for example, by the Nuffield Trust in its *Integration in action* case studies, and by the Local Government Association report by Professor Gerald Wistow, *Integration this time?*, point to how such a strategic overview definition could be developed and framed. It would help rebalance the Bill into more of a health and social care Bill. Does the Minister intend to clarify and define integration in the Bill?

Finally, in closing, I want to stress our recognition of the importance of the future role that health and well-being boards need to have in ensuring integrated services and promoting patient and public involvement in the commissioning of services. We support health and well-being boards and the health and well-being strategy—in the context that the local authority has real powers over its implementation.

Moreover, if health and well-being boards own the well-being strategy then they must also own the plans to deliver it. CCG commissioning plans should be agreed by the health and well-being board, and we will be putting down amendments which seek to give the boards this important power of sign-off. Only in this way will we achieve genuine joint ownership between boards and CCGs of commissioning plans which match local needs and are firmly based on the health and well-being priorities of the local community.

7.34 pm

Lord Colwyn: My Lords, before saying a few words about the National Health Service dental service, which I would remind my noble friend is not entirely free at the point of delivery, I should remind the House that I have actually worked as a dental surgeon in the health service for more than 25 years.

This is a time of great change for dentistry. Alongside the changes to commissioning introduced by this Bill, the next few years will also see the introduction of a new NHS dental contract, with a greater emphasis on prevention. Pilots for this contract started last month in 67 dental practices across the country, and are due to run for at least the next 12 months. On the whole these changes have been warmly welcomed by dental professionals, because they start addressing the lingering problems that the previous set of reforms created in 2006. Nevertheless, there are a number of points where there is still a need for more detail and greater clarification, and I hope that the Government will be able to address these issues as the Bill progresses.

Dentists strongly support the decision that the commissioning of general dental services and secondary dental care should be carried out by the national NHS Commissioning Board. This arrangement has the potential to be a considerable improvement on the current system of PCT commissioning, which has resulted in inconsistencies across the country. However, if these arrangements are to deliver improved dental provision, there is a clear need for expert dental advice to be available to the Commissioning Board to inform its commissioning decisions. At present there is nothing in the Bill that explains who will offer this advice, or the mechanism by which it will be provided.

At a national level, local expertise will also be vital in the new commissioning arrangements. When the Commissioning Board makes decisions about service provision for specific areas, it will not only need to call upon expert dental advice, it will also need an input from professionals with local dental expertise. This local input is a key element that the Bill has yet to cover and the Government need to clarify how they will utilise the existing sources of local dental expertise, such as local dental committees, in the new commissioning arrangements.

The role of consultants in dental public health will also be of great importance, particularly given the Government's reform of the public health system and the changes that the Bill makes to the public health responsibilities of local authorities. The *Healthy Lives, Healthy People: Update and Way Forward* Command Paper, which the Government issued in July, explained that under the new arrangements they envisage that specialist dental public health expertise will become part of Public Health England, a move which would be welcomed by many consultants in dental public health.

However, their expertise will also need to be available to local authorities, in particular to the new health and well-being boards. Much more detail is needed as to how these new arrangements will work in practice. At present it also appears that there will be no obligation on health and well-being boards to take advice from, or consult with, any source of local dental expertise when drawing up a health and well-being strategy and a joint strategic needs assessment. The Government should consider whether there is a case for giving them a statutory duty to do so.

It is very unclear what role, if any, Monitor will play in the regulation and licensing of dental practitioners. The profession is already subject to a significant burden of regulation, with dentists regulated by the General Dental Council, by the Care Quality Commission, through Performers Lists Regulations and through their regulatory and contractual obligations to the NHS. It would not be appropriate for Monitor licensing duties to cover dentistry. It could be argued that it would impose an unnecessary burden which would be contrary to Monitor's duty to review regulatory burdens, as set out in Clause 64 of the Bill. I ask the Minister to clarify this issue and to confirm that dental services will be exempt from licensing by Monitor.

As I said in my opening comments, this Bill is just one aspect of the Government's reforms of dentistry. If the benefits of central commissioning and the new public health arrangements are to be fully realised, it is vital that the Government also stay focused on the pilots for the new contract. The pilots may not be part of the Bill, but they are central to the reforms of NHS dentistry that the Government are pursuing. I hope that the Minister will maintain the Department of Health's commitment to a co-ordinated approach and that they will drive forward progress on the pilots alongside the reforms contained in the Bill.

I shall conclude with a couple of issues associated with indemnity. Outside the indemnity provided by the NHS, doctors and dentists have to make their own indemnity arrangements for clinical negligence claims. My noble friend will be aware of the massive costs to the NHS that arise from negligence and other errors. The Bill is silent on indemnity, but must be amended to address the arrangements for clinical negligence indemnity in respect of services commissioned by clinical commissioning groups and the National Commissioning Board. There should be clear guidance specifying the type and amount of indemnity that is required in order to protect patients.

Clauses 251 to 259 relate to the powers of the Health and Social Care Information Centre to require, publish and otherwise disseminate information, including patient identifiable information. There are two specific areas of concern around patient confidentiality and conflicts of interest. I was intending to read out the relevant clauses, but owing to the restriction on time, I shall just draw my noble friend's attention to Clauses 255(1) and 255(7). As currently drafted, the Bill appears to provide wholly inadequate protection against inappropriate disclosure of patient identifiable information. It removes important rights to confidentiality and would place doctors and dentists in an unacceptable position. There is concern that any protections afforded by the Data Protection Act would not apply in these circumstances.

The Bill, if enacted as currently drafted, would require doctors and dentists to ignore their regulatory professional obligations and it abolishes their common law duty of confidence. The indemnity organisations seek clarity as to whether the Secretary of State has, or intends to issue, guidelines about dealing with conflict of interests and what the legal status of any guidelines would be. They should also be able to understand what other steps are to be taken to ensure that there are adequate and appropriate arrangements in place to manage real, perceived and potential conflicts of interest for clinicians who may be providers, commissioners and performance managers as well as having financial interests in other providers.

I hope that the Bill will progress to a Committee stage unhindered by both amendments.

7.41 pm

Baroness Andrews: My Lords, under normal circumstances one might have thought twice about taking part in the debate on a Bill with so many speakers of such expertise. However, this is in no sense a normal Bill, as so many noble Lords have made clear. It was presented as a fait accompli, without prior mandate or consultation; and such is the Government's anxiety to put these changes beyond reach that they began with implementation, proceeded to legislation and concluded with consultation. The noble Earl spoke in his opening remarks of the intense scrutiny that the Bill had received in another place. Many of the changes enforced on the original Bill have yet to be debated at all. The failure regime is yet to be put before us, and critical parts of the process have been undebated.

We are therefore looking at a Bill that breaks some of the basic rules of democratic engagement. Given the fears that have been raised by what is proposed, and the fact that these most radical changes are being introduced against the greatest financial slowdown in the NHS since the 1950s, it is a duty and a privilege that we can make our voices heard, as so many people outside this House have asked us to do. I argue that the bigger the reforms, the bigger the mandate needed. This Bill may have moved away in some sense from the more extreme political ambitions for a future NHS powered by market forces, but it has left behind a morass of confusion and dismay.

Medicine, par excellence, is evidence-based; and there is evidence of how the NHS has improved. In fact, for the first time for decades, the NHS is off the front pages of the tabloids. The evidence we have, for example, of real progress in areas such as cardiovascular disease and stroke can be attributed, according to the man who led the changes, Sir Roger Boyle, to collaboration—not a word that we see in this Bill, yet. Many noble Lords, quite rightly, have spoken very powerfully of the evident need for change in the NHS and the consensus that can be built around change—driven by new possibilities, new knowledge and new expectations, but also by the inescapable challenges of an ageing society and new threats to public health.

[Baroness Andrews]

Despite the recent—and very welcome—letter from the Minister, which set out the necessity for modernisation, one of the critical failures of the process around the Bill is that there has been no compelling public narrative or debate around that necessity. That would have enabled us all to test out the proposition that the provisions in this Bill were the only solution to the challenges of rising demand, rising costs and rising aspirations. I wonder what other organisation the size of the NHS—£128 billion—would plan change without such a narrative on which to build consensus, or an evidence base that could have been publicly contested. As the noble Lord, Lord Darzi, said—and he should know—change can happen when everyone comes together: leaders, managers, clinicians and patients. The tragedy of the situation we face is that there is, indeed, an irresistible and entirely responsible case for change, which could have consolidated a proper role for clinical commissioning, competition to raise quality, greater integration of services and greater choice, without raising the spectre of a market in health and without undermining the ethical basis of the NHS.

Above all, that case for change could have been won without exposing the service to "irreparable harm" and patients to greater risks. Those, of course, are the words of the 450 public health doctors last week. Yes, the Government have introduced important changes to the original Bill, but surely they should never have been needed in the first place—broader clinical leadership in terms of commissioning groups should have been a given. In particular, Monitor should never have been charged with a mandate to promote competition. Some things in the Bill are overdue and some are certainly worth supporting—for example, the health and well-being boards—but the Bill has now lost whatever coherence it might have had. Instead, it has turned into a sort of Frankenstein of a Bill; a lumbering improvisation of stitches, patches and mechanics. I do not want to push the metaphor too far, but the noble Earl will know that the original monster died pathetically from a lack of understanding and love. We will not, I can assure this House, let that happen. Instead, we have to work with a Bill that raises profound and distracting questions about constitutional responsibility, accountability and workability, and which is shot through with risks. It is those risks that I want to talk about.

The greatest risk is the uncertainty, following the changes to Monitor's role, as many noble Lords have alluded to, about where the limits to competition will now lie and to what extent this is within control. Monitor may now have become a body intended to prevent anti-competitive behaviour when it is not in the interests of the patient. What on earth does that mean in practice? How will it relate to competition law? How will integration, in practice, relate to choice and competition?

I was told this morning of an instance where local GP practices wanted to offer teledermoscopy for the quicker and faster identification of malignant moles by way of photography. A local private company wanting to bid for the service has mounted a legal challenge, which has now stopped this possibility in its tracks while all this is sorted out. Imagine this sort of instance multiplied across the health service in various disciplines while patients wait and conditions worsened.

The Minister also spoke of a new level playing field for providers. The Government may want to believe that these new services will be run within the benign culture of social enterprise. In fact, we already have compelling evidence, from the failure of Central Surrey Health, that even the Government's flagships cannot compete with the large private providers. Why else would Central Surry Health have lost out to Assura, which is 75 per cent owned by Virgin? If it cannot compete, frankly, who can?

The second and related risk is the congested landscape of commissioning, which has been very well described by other noble Lords. The organigram is enough to raise anyone's blood pressure. The Minister referred to the NHS being consumed by layers of bureaucracy. However, he will have heard time and again—and he will go on hearing, I am afraid, from the next 50 speakers—that there are deep concerns about the new layers of bureaucracy, the landscape of decision-making, the higher costs and greater fragmentation; and, therefore, about the command and control role of the NHS Commissioning Board.

I have a few specific questions about the future of local services and commissioning. Can the Minister tell me, for example, how many patients are still not allocated to commissioning groups? Can he tell me who will now own the local hospital—previously the clear responsibility of the PCT—where there are possibly two competing providers that cross local authority boundaries? Can he tell me what will happen if the money runs out half way through the financial year when commissioning groups are still not in place? Some practices are still in the dark—although they know they have to take on extra staff, not least an accountant, because they do not know their budget for next year.

These are questions put to me by GPs, who say they are keeping them awake at night. As one described his new responsibilities: "If I had wanted to be a town clerk, I would have been one". He actually put it rather more strongly than that. This confusion around the delivery and configuration of services in the future, which are major questions of capacity and responsibility, is precisely why we need absolute confidence in the role and the responsibility of the Secretary of State. I know the Minister is particularly good at listening. He helped the last Government improve their legislation and we have a genuine coalition across this House in the making of policy, which was to the huge benefit of the health service. He has made it clear he wants to work with noble Lords and I hope some way will be found out of the impasse over reference to the Select Committee. It will be a way of building confidence—and that is central to our task in this House.

We have been put in a very difficult position. We are seen as the point of last resort and reason. We will not play politics with the NHS, but neither will we cut short our scrutiny just because the Government have gone ahead and started dismantling the service on the ground before Parliament has decided what is right. This is a problem of the Government's own making and our absolute and clear duty is to scrutinise and

challenge the Bill as fully as we can. I fully support the reference into a Select Committee, particularly of Part 3 of the Bill, which I think desperately needs to be challenged and unpicked. Yesterday, one of the many messages I received simply said:

"I have never known people generally to be so looking forward to the Lords doing their duty".

We shall do our duty.

7.50 pm

Baroness Tonge: My Lords, whatever the noble Earl, Lord Howe, said earlier, we were promised by both parties before the general election that there would be no top-down reorganisation of the NHS. It did not appear in the coalition agreement either and therefore this Bill should not have appeared at all. The noble Lord, Lord Rea, made the arguments for his amendment superbly in his speech and I do not propose to repeat them, but the Bill has no mandate; it is undemocratic and I hope it will be thrown out.

I did not come in to this House because of great works in the NHS, as many colleagues here did. In fact, I am never quite sure why I did come here. But in the NHS, I was a doctor; my children called me a barefoot doctor, working mainly in women's health screening and family planning. I managed community health services, district nurses, health visitors, the physios, the speech therapists, the porters, the admin staff—all the professions allied to medicine: the poor bloody infantry of the NHS. They come into very personal contact with the patients and they need to be spoken for.

My job changed with each reorganisation and there were very many of them in the time I served. I was a middle manager, trying to keep the staff happy and patient-focused while we underwent each upheaval. Each one wastes a great deal of time and money and, above all, it takes staff away from patient care. A 4 per cent efficiency saving—very lightly called the Nicholson challenge this time—is enough to cope with and may precipitate a lot of change on the way staff do things anyway. But they cannot cope with the uncertainty of this Bill at the same time. In any case, what is the point? The PCTs could have been ordered to include clinicians on their boards and management teams. Some do anyway. An inspection of the way PCTs conduct their business would be useful: there are some PCTs that are not very efficient and are overstaffed. But there are experienced teams that are coterminous with the local authorities, and that will be lost with this Bill.

The GP commissioning groups will need a bureaucracy; they are not going to do it at night after work. Nothing is stopping them employing private medical companies to advise or even do the commissioning—private medical companies spending NHS money and which may be commissioning from their own providers. I find this a nightmare. How long will the NHS survive this scenario?

Many of my old colleagues—and I was with a lot of them last week, which is why I was not here—think that this is the main purpose of the Bill: to gradually privatise the NHS. This view is shared by the thousands of people inside and outside the NHS who have sent individual letters, anecdotes and briefings to us all. Are they to be totally disregarded? We must also consider the effect of letting GP groups decide on the availability of treatments in their area. This will totally disrupt the doctor-patient relationship.

The Secretary of State for Health says that the NHS is broken. The Minister earlier quoted OECD statistics, but other international bodies do not agree with him. According to the World Health Organisation, we have similar health outcomes to Germany, which on the most recent figures spends 2 per cent more than we do. France has slightly better outcomes, but it spends over 3 per cent more than we do. Everyone knows that the USA has poor health outcomes on a much higher expenditure. The King's Fund and the RSM, to which I refer noble Lords, have also said very good things about the efficiency of our health service. If it ain't broke, then don't fix it.

The noble Lord, Lord Darzi, argued earlier that changes were already occurring—that the PCTs were being broken up. I ask the Minister whether it is legal for that to be happening already. The noble Lord told us about the patient under anaesthetic who would die if the operation was not allowed to proceed. I have a lot of respect for the noble Lord, but just consider: if the patient had not given proper consent and the wrong operation took place on that patient, causing the patient to die slowly and in agony, it would be just like the NHS following this very wrong operation. It is better to stop now and think.

The point which is most frequently made in defence of reorganisation is that health needs are changing. I have a very good joke about this which some of you may have already heard. If so, noble Lords should put their fingers in their ears. For those who have not heard it, it is worth it. When the health service was founded, it cared for us from the cradle to the grave. It then had to cater from the womb to the tomb. Then, as medical science progressed, the health service had to provide from the sperm to the worm. The problem with the health service now is that it has to provide for us from erection to resurrection. That is the problem; noble Lords should think about it.

We need more care in the community than ever before because of our ageing population and we need provision for more and more complicated and wonderful treatments available. The general public understands this, and also understands that resources are finite. Choices are going to have to be made about what we provide on the NHS. As the noble Lord, Lord Owen, has said, rationing already occurs—it has to. We need a national consultation and debate about what the health service should provide and where. The general public should be consulted as well as health professionals. We have not done this.

I urge noble Lords to think out of the box: be brave—show the British people that the House of Lords is really worth a place in our national life. Throw out this Bill entirely by voting for the Motion in the name of the noble Lord, Lord Rea. I say this with great sadness: my party is taking part in what I and my old NHS colleagues feel is the ultimate destruction of the NHS, which has been, and still is, the envy of the world. We should be ashamed of this. I am.

7.59 pm

Baroness Armstrong of Hill Top: My Lords, I would first like to declare my interests. My husband works as an independent consultant, largely in health, and I am a non-executive director of County Durham and Darlington foundation trust. I always enjoy listening to the noble Baroness, Lady Tonge. When we were together in the other place, I always enjoyed what she had to say, but when I was Chief Whip I was very pleased that she was not one of my charges.

We come to debate this Bill today with many members of the public expressing confusion and anxiety, almost at best, about it. The tragedy is that we did not need to be here. The public got used to NHS reform over the past decade and, indeed, one of the reasons we were elected in 1997 was their concern about the state of the National Health Service. They liked the outcomes of our reforms; they liked shorter waiting times, new hospitals, new GP surgeries and more choice. They felt, and they told pollsters, that it was better than they had known it, and it was more popular with the public than ever. When they were elected, this Government could have decided to get cross-party agreement and build on those reforms. One would have thought that that would be in the spirit of coalition politics, but no. Instead, despite what was in the manifestos and the coalition agreement, we were promised a revolution in the NHS. Then, after the pause, we were told by the Prime Minister, and were presumably meant to be reassured, that actually nothing much would change in the NHS. I think he said that the NHS would remain largely the same.

Today, I am still not sure what the Government believe and what they want. I have sympathy for the Minister who has always been incredibly generous with the House as a whole and with individual Members. He is certainly doing his best, but I am afraid that his Secretary of State has not been giving us clear, consistent messages. The Government had a very clear message on tackling the deficit. Even if I did not agree with all their prescriptions on that, I knew what they were, I know what they are today, and I understand where they are trying to get to. However, the NHS has not been dealt with or talked about in the same clear way. We were told that the NHS was outside the tackling of the deficit and its budget was to be protected. It is being protected, but all of us know that that is not sufficient. If we keep going the way we are, the increase in the budget would have to be phenomenal, and the economy could not bear it. But we have had this confusing message, and that is what the public have heard. They have heard, "Money is being protected, so we do not need all this reform".

What has actually happened is that the Government have simply failed to explain what they want to do and why, and we have had a major failure in the politics of handling reform. I believe that has taken us back years. When he came in, the Secretary of State immediately halted reconfigurations that were going through the pipeline, particularly in London. Now, I understand that all those decisions have been reversed, and the reconfigurations that were in progress and in programme have continued. Eighteen or 20 months later, what has that cost in money and probably also in lives? This confusion, this inability to be consistent and clear, has led all of us to lack confidence in what the Government are seeking to do. The measures in the Bill will make reconfiguration much more difficult, and we will need to look at, for example, what the King's Fund is advising on this. I will certainly want to come back to that in Committee because I believe that whatever changes are needed in the health service will have to be approached in a very agile way. I am terrified that the Bill will reduce what agility there is—and there ain't very much there now.

The reality is that no matter how long the Government manage to protect the budget of the NHS, great changes will still be needed in years to come. Given the trends in the economy, reductions of 3 or 4 per cent a year will not be enough. If there is not enough ability to make major changes, what we will see is simply cut after cut that will end up with a reduction of service year on year. These arguments are difficult, but the public have the right for us to make them, and the tragedy is that the Government have ducked them. As many noble Lords have said, the challenges come not just from the economic crisis, they also come from changes in the population, particularly with regard to the increase in the number of people with long-term conditions, the increasing number of people living longer—which is a good thing, but it will put increasing demands on the health service—and changes within healthcare itself. These push us into changing the way we offer care and support patients. This Bill was an opportunity that, to date, the Government have squandered. I find it difficult to believe that such a strong clear case could be so messed up by a Government in their first couple of years.

My noble friend Lord Hutton said many of the things that I intended to say, so I have cut most of them out, but I, too, remain unconvinced that the key objectives will be met by the Bill as it stands. One of the objectives is to reduce bureaucracy, but I have said a number of times to the Minister that the number of organisations is increasing and the coterminosity with local authorities is being lost, which will increase bureaucracy, not reduce it. The localisation of decisions is simply not happening in the way that we all know it needs to. The power of the national Commissioning Board is increasing, and the more that is given to it, the more it will control what will go on rather than decisions being made locally. We will have to come back to all these things during the passage of the Bill. We will need to come back to choice and competition. I want to mention one other issue: people who have multiple needs. They may be homeless, mentally ill or addicted. I am unconvinced by any of the arguments that I have heard that the Government are properly addressing them, and I will want to come back to this.

The *Financial Times* today says of this Bill:

> "What has emerged can best be described as a dangerous hotchpotch of measures certain to bring tears to patients and politicians".

In my angrier moments, I say to myself, "Let them get on with it. They are making a real mess of this. Let them get on with it and let the Government pay the price". The problem is that it will not be the Government who pay the price. It will be the people of this country,

and therefore we in this House have a responsibility to look after them and the NHS, and that is what we will seek to do.

8.08 pm

Baroness O'Neill of Bengarve: My Lords, like other noble Lords, I return to the theme of accountability and the approach taken in the Bill. However, I am going to say only a very little about accountability to the Secretary of State. I fully agree with the Government that that accountability should not be managerial or executive. There is something absurd about the locution that has it that the Secretary of State delivers services. We have many organisations in which accountability to the top does not rest on the top having executive power. Charities and schools, corporations and universities do not hold to account by using managerial or executive powers. They hold managerial and executive powers, and those who exercise them, to account. In these types of institutions, accountability, as we know, is variously to trustees, governors, boards, councils and so on. Accountability in the NHS will be distinctive, and it needs to be clear that the Secretary of State is not on the hook for every failure of delivery. However, he or she needs well-defined powers for dealing with a range of contingencies, of which the noble Baroness, Lady Williams, and the noble Lord, Lord Marks of Henley-on-Thames, reminded us.

Getting this right will not be easy, but I hope that we can achieve acceptable clarification within the timetable of the Bill. I hope that this might be done by allocating additional time on the Floor of the House in Committee, even at the expense of other legislation, and that the usual channels will look on the necessary adjustments sympathetically. I am privy to nothing and I may be mistaken in that hope.

The forms of accountability to which I mainly want to draw your Lordships' attention and about which I want to talk at greater length are much less exalted. Many noble Lords have emphasised the importance of cultural change if the new structures are to achieve what the Government hope they will. However, we all also know that demands for detailed accountability come trooping in the wake of legislation. They accumulate in regulations, codes of practice, guidelines and guidance, and all of these can militate against cultural change by requiring NHS staff to follow time-consuming procedures that are often perceived as tedious and bureaucratic, and that may even damage the very services to patients for which staff are being held to account. Over the years as we have gone through one piece of legislation or another, noble Lords have often heard Ministers reassure the House that some lacuna or difficulty in a Bill will be dealt with later by adding regulation, guidance or codes of practice. I fear that the record of mopping up the difficulties of an Act by such add-ons is not very encouraging—and can be extremely discouraging to those so held to account.

Excessive and ill-designed forms of accountability for front-line staff may not only demoralise but have detrimental effects on the very services for which they are held to account. Where health professionals are distracted or harassed by ill-designed forms of accountability that they perceive as destructive, wasteful or unproductive, or simply as excessively bureaucratic, cultural change will be undermined, and productive and co-operative working relations will be made harder and may indeed be prevented. Unfortunately, examples of destructive, wasteful and unproductive accountability requirements are not uncommon.

As an example of destructive forms of accountability we need only consider those cases where accountability creates perverse incentives to act in ways that undermine or damage the very activities for which people are held to account. To take an example that is, I hope, out of date, some interpretations of accountability for achieving targets for waiting times incentivised the diversion of effort into, let us say, imaginative ways of logging the "beginnings" of waiting times. As I said, I hope that this example is out of date, but it would be naive to imagine that perverse incentives will never be introduced—always with the best of intentions—and the Bill needs to incorporate measures to provide for realistic challenges to proposals for additional forms of micro-accountability.

As regards wasteful forms of accountability, I offer an example that I met a few years ago when chairing an inquiry into the safety of maternity services in England for the King's Fund. A midwife told us in evidence, "It takes longer to do the paperwork than to deliver the baby". I have no doubt that that was a bit pithy and exaggerated but her words have stayed with me. While I have no reason to think that a consequence was that the women in labour received inadequate care—although it is possible that this happened—or that the requirement to complete this paperwork actually destroyed good clinical care, this was surely a waste of the midwife's skills and of NHS resources.

With regard to unproductive forms of accountability, I offer the example of requirements for NHS staff to log data that do not provide useful feedback for them. While accurate statistics matter for many purposes, the provision of formative feedback to those who compile the information can matter most, and it can change a mindlessly boring clerical task into one that has a point and can even be motivating. An NHS that prioritised formative uses of information would enable healthcare staff to find out more about their own unit's performance and its strengths and weaknesses.

I recognise that Ministers would never intend to introduce destructive, wasteful or unproductive forms of accountability, but I fear that, because accountability creeps in the wake of legislation, it often turns out to be unintelligent or defective in more than one way. The demands for better regulation that have been extolled, and indeed encouraged, for so many years have often proved ineffective. Therefore, if we want intelligent accountability we shall, I think, all need to take a very active view of how this can be achieved, and accept that with accountability more is not always better; indeed, it can paralyse.

That control of the proliferation of damaging requirements for accountability also affects medical research. For example—the noble Lord, Lord Willis of Knaresborough, and the noble Baroness, Lady Morgan of Drefelin, referred to this—current interpretations of the Data Protection Act 1998 impose an extraordinary and, in my view, unnecessary burden of complexity on clinical research in this country.

[Baroness O'Neill of Bengarve]

Therefore, I should like to ask the Minister what steps he proposes to take to prevent and deter the creation of reams of additional, time-consuming, excessive and even destructive forms of micro-accountability in the NHS as it emerges from these changes. Could he perhaps consider a Churchillian move by assigning to the new institutions a duty to penalise the promulgation of excessive forms of micro-accountability, perhaps by insisting that such documentation be written in plain English and be no longer than a single side of A4? Oh that he could, but I doubt that that is possible. Or are we to believe that the intentions of the Bill will magically stem existing predilections for excessive and sometimes stupid forms of accountability?

8.17 pm

Lord Brooke of Alverthorpe: My Lords, I want to address my remarks to Clauses 8 and 9 on protecting and improving public health. As we all know, if we could move public health policies higher up the agenda and seriously start to address some of the fundamental health problems facing us, the savings that would accrue would not only lead to a better lifestyle for many of our population but go a long way towards easing the financial problems facing the NHS.

The major health problems confronting us have not just descended on us. It is worth recalling that it is now nearly a decade since Sir Derek Wanless was asked to look into the NHS. In 2002, he produced his first report in which he forecasted that, unless people can be persuaded to lead healthier lives, NHS costs would spiral out of control. He suggested a number of options for the way forward, ranging from, on one side, full engagement with the public health agenda to, at the other extreme, a minimal programme and uptake at fairly minimal expenditure compared with the rest of the NHS budgets. If the latter option were chosen, he warned that the NHS would have to meet additional costs of £30 billion a year by 2020.

Wanless was then asked to do a further piece of research and, in 2004, he delivered a report focusing on transforming the NHS from what he described as basically a national sickness service into one that was about preventing sickness, which is now proving so prohibitively costly to us. He offered a range of ideas, including a ban on smoking in public places, taxing fatty foods and boosting physical activity, with the main onus on motivating individuals to take better care of their health. He identified the main threats which could reach epidemic proportions as being obesity and its related illnesses, alcohol abuse, smoking and sexual health issues. That was back in the early part of this new century and those issues are still before us. His report anticipated that, unless positive actions were taken to improve public health, by 2050 we could expect 60 per cent of our men and 50 per cent of our women to be obese, with 25 per cent of our children falling into that category, with a consequentially steep rise in heart disease, strokes, cancer and diabetes.

Regrettably, as we all know, Wanless's warnings have not been heeded and acted on. Since then, there has been only one significant major lifestyle change for the better: the ban on smoking in public places. Notwithstanding the brickbats which he has received recently, I congratulate our former Prime Minister Tony Blair on having the boldness and the guts to stick with that and to force it through against some very severe opposition at the time. Regrettably, we did not maintain the same fervour for driving through the other changes needed.

The issues that clearly stick out are fatty foods, sugar and alcohol. The drink and food industries were successful in persuading us that self-regulation was the way forward rather than resorting to legislation. There have been some self-regulated changes since, such as the traffic-light labelling on excessive fat, sugar, salt and calories. Not surprisingly, the industry even disagrees among itself about how that should be put forward and we have ended up with two sets of traffic lights, which leads to confusion among the public. Self-regulation has moved in the right direction, but not particularly well and at a very slow pace.

In the mean time, we now have even more worrying forecasts about the spread of obesity and related illnesses, and the facts on alcohol are equally depressing. Average consumption of pure alcohol has nearly doubled from fewer than six litres per person in 2000 up to 11.5 litres in 2008. Alcohol, which is now 62 per cent cheaper than it was in 1980, makes a major contribution to obesity, weight gain and problems such as diabetes which are often associated with obesity.

I know that the noble Earl has been very busy recently but he may recall that I recently asked him a Written Question on this topic. I asked him when the Government,

"last had discussions with the food and drink manufacturing industries about adding information on calorie contents to the labels of alcoholic drinks; and what was the outcome of those discussions".

His response stated:

"The Government have not met the food manufacturing industry about adding information on calorie contents to the labels of alcoholic drinks.

The department last discussed the inclusion of calorie information on alcohol labels with the Portman Group early in March 2011. The Portman Group's guidelines on alcohol labelling refer (in paragraph 3.11) to the possibility that individual companies may wish to trial presentations of such information on labels".—[*Official Report*, 3/10/11; col. *WA 95*.].

We shall wait and see what happens on that with the Portman Group. That kind of response raises little optimism for me about self-regulation and about the value and effectiveness of the long-awaited strategies that are coming on obesity. The same applies to the long-delayed publication of the coalition's strategy on alcohol.

On a pleasanter and more supportive note, I am very pleased that the Government have decided to devolve some of the public health issues down to localities. However, those of us who tried recently to amend the alcohol licensing provisions in the recent Police Reform and Social Responsibility Bill, to extend the criteria for granting licences to sell alcohol to take into account public health consequences, ran straight into a brick wall with the Government. I would have thought that giving localities the power to deal with wide-scale issue of licences in many areas, which many local medical people oppose, was the kind of issue that,

under the devolved arrangements set out before us, would be embraced with alacrity by the Government, but they rejected it.

Like others who have spoken today, I have considerable confidence in what the Minister does within this Chamber. I should like him to try to convince me that the new health and well-being bodies that are going to be established will have some real teeth and will not end up merely as talking shops for canvassing views and establishing strategies and needs, which in reality will deliver little more than did many of the strategies that my own Government produced in recent years.

I should also like to ask the Minister, based on a briefing which he gave recently, whether it is intended that local bodies will be required to operate within the strategies which have been drawn up at national level. That was my understanding of what he said. If so, I shall be concerned that we may end up with weak central strategies leading to weakness down the line. What facilities will there be for people to amend the national strategies at a faster pace than has normally been the case in the past?

Finally, I come back to where Wanless took us in the early part of this century. We have two options. The first is minimal spend on public health policies and continuing difficulties with alcoholism, obesity, sexual health and so on; the other is spending even more money on public health in the future than we have in the past. Are the Government prepared truly to pin their colours to effecting a major change there, so that we can see a shift in the allocation of the money being spent on public health within the NHS budget?

8.27 pm

Baroness Eccles of Moulton: My Lords, I am delighted to support this Bill. It is a good Bill, which has moved on a lot since it was first presented to the other House in January. The listening exercise in the spring has been described as a sign of weakness by some, but a Government who listen to people's opinions and are not too fixed in their position to accept improvements is refreshing. Equally, the Future Forum's invaluable work and the changes proposed in its report have put this Bill on a much surer footing. I would particularly like to acknowledge the contribution of the Secretary of State and, of course, my noble friend the Minister for so readily accepting its core recommendations. All will agree that, as long as we end up with a Bill that works for patients, which we must not forget is crucial, the rather choppy ride that it has received through Parliament will be all but forgotten.

This evening I shall focus also on public health. It is such an important subject that I am pleased that, by extraordinary coincidence, the noble Lord, Lord Brooke, has already spoken to us on it and focused your Lordships' minds on it. Public health is one of the key areas in the Bill and is a topic that we so often forget to talk about.

What do we mean by public health? So often when we hear the term, it evokes memories of the great Victorian public health Acts of 1848 and 1872. They sought to reduce the levels of cholera and dysentery by providing more hygienic waste disposal networks and sanitising water supplies. Those were pressing issues in those days. Today, public health is still faced with many problems. Some of them have been around for a long time, although they change in shape and form as time goes on. Examples, which have already been mentioned by the noble Lord, include poor mental health, alcoholism and substance misuse, although there are many more. One that stands out as a new threat to health is obesity. It is important that these problems are tackled head on through this Bill. I do not know how many of your Lordships listened to the debate introduced in the Chamber last week by the noble Lord, Lord Crisp. Many of your Lordships might know that obesity is a subject on which my noble friend Lord McColl focuses a lot. My noble friend's speech last Thursday was very much focused on the principle of eating less. He reckons that if people eat less they will not weigh so much.

England's NHS budget increased from £35 billion in 1997 to £106 billion last year. However, for reasons that it is difficult to understand, there seems to have been little attempt to focus on preventive measures and public health in general. I am repeating a bit what has already been said. The scale of the problem is alarming. Every year 18 per cent of all deaths can be attributed to smoking; there are around 15,000 premature deaths per year in England associated with alcohol misuse; and more than half of all adults are overweight or obese. Poor public health inevitably affects the most vulnerable communities in our society.

We need to have a greater awareness of the importance of prevention. Talk to any public health expert and they will extol the virtues of preventive approaches and early interventions. Preventive public health strategies can include innovative health guidance, talking therapies, effective targeting and community care. All have proven benefits. They are, however, sadly all too often missing from commissioning strategies. Therefore, any effective public health strategy must have persuasion and prevention at its heart. The Bill will have many positive influences in these areas. For example, for too long money that was given to local health trusts and earmarked for public health was seen as a general pool to dip into when times were tight. This is why it is very helpful to see a commitment from the Secretary of State to ring-fence public health funds. At last local areas will have budgets that are safe, secure and will be spent on public health.

At a national level there is a rationale for health protection to rest with central government, as the nature of various threats to health, ranging from infectious disease to terrorist attacks, are not generally amenable to individual or local action and clearly need to be centrally organised. As a result, the disappearance of the Health Protection Agency and the transfer of its responsibilities to the Secretary of State and Public Health England are to be welcomed. More locally, directors of public health will be the linchpin behind the intended public health reforms in the Bill. Giving these directors budgets and providing a democratically accountable leader for improving health in a local area is entirely welcome. Co-ordinating those engaged in public health will also be important.

The NHS Commissioning Board will be commissioning extra health visitors. The clinical commissioning groups will be commissioning certain public health services

[Baroness Eccles of Moulton]
and will also be working closely with the new health and well-being boards. These organisations will need to work together in an effective way. This will require strong leadership from the directors of public health. To do this, these positions will need to be given the flexibility and independence that will attract strong candidates. It is not yet quite clear that, as they currently stand, they are seen in this light. Are they the interesting, important roles that give the opportunity for outstanding candidates to make a real difference, or will they give directors the responsibility for changes that they will not have the authority to achieve? My noble friend the Minister will want to look at this area very closely in Committee.

There is much to support in the Bill. It is said that we do not need the many changes—that in times of austerity too much is at risk. However, the problems we face are too serious for inaction. I hope that this Bill will initiate a sea change in the way that we approach the nation's health and be a worthy successor to the public health Acts of long ago.

I will not be supporting the amendments of the noble Lords, Lord Rea and Lord Owen. It would not be right for the health service to be kept waiting any longer for the Bill by delaying the Bill's passage through the House.

8.34 pm

Lord Touhig: My Lords, people with autism routinely struggle to access the health services that they need. Consequently, outcomes for children and adults with autism are poor. I wish to focus my remarks on how I see the Bill affecting them.

It is a fact that 70 per cent of children with autism also have one or more mental health problems, yet research by the National Autistic Society shows that child and adolescent mental health services are failing to improve the mental health of two-thirds of children who access their services. A third of adults with autism say that they have experienced severe mental health problems because of the lack of support. People with autism are often disadvantaged in accessing health services as their needs are not properly recognised and understood by professionals.

In a debate in this House on 1 March, I pointed out that 80 per cent of GPs who were audited by the National Audit Office said that they needed additional guidance and training effectively to support patients with autism. Research conducted by the National Audit Office into public spending on autism found alarming gaps in training, planning and provision across a range of services.

The National Autistic Society tells me that it has some concerns about elements of this Bill, but it also sees an opportunity to address long-standing inequalities. Based on its briefing, I would like to share some ideas so as to be constructive about the Bill and to leave the Minister with some questions to answer.

One of the best ways to resolve structural and data problems is to establish specialist autism teams within the local authority area or GP consortium. The adult autism strategy for England, published in April 2010, recognised that where things were working well in a local area this was often as a result of the development of such a team. It recommended that the new bodies look at the models of teams that have been established and consider developing one locally.

I share the warm welcome that the National Autistic Society has given to the drive towards joined-up working, but I also share its concerns about how such teams will be commissioned and funded in the future. How will the NHS Commissioning Board oversee the commissioning of specialist autism services? How will the Government and the NHS Commissioning Board incentivise GP consortia to work with the local health and well-being boards to ensure the setting up of specialist autism teams, such as the Liverpool Asperger Team, which has been shown to be very cost-effective?

Currently, several specialist autism teams are jointly funded by PCTs and local authorities. But if 80 per cent of the commissioning budget sits with consortia while the health and well-being boards are responsible for the commissioning of joint services, there is a worry about major budgets held by GPs who may not decide to commission services whose primary benefit in the short and medium term will be to local authorities. That commissioning problem could become more complicated when a health and well-being board has a number of consortia in an area.

The NHS Future Forum recommended that wherever possible there should be coterminosity between local authorities and GP consortia. However, there will still be a number of GP consortia within a local authority area, so mechanisms will be needed to ensure that the consortia and the health and well-being boards can work together effectively.

Currently, the proposal is that a health and well-being board can send back a commissioning plan to GP consortia if it believes that it needs revision. However, there is no mechanism for resolving disagreements between these boards and the consortia. Do the Government agree that an arbitration service may be necessary to help resolve conflict between the consortia and the health and well-being board?

More, the National Autistic Society has significant concerns that unless GPs and others on the GP commissioning consortia are given the necessary support, they may struggle to commission the right services for people with autism. Do the Government agree that quality standards need to be at the heart of commissioning decisions made by GP consortia? What progress has the health department made to ensure that autism is part of the core training for doctors—an issue which we have debated for a long time? How do the Government intend to ensure that autism training is available to GP consortia?

We all know that autism is a complex disability, and many professionals will not have sufficient understanding of the needs of that group, nor of what services are necessary to meet those needs. As such, they need guidance, training and, of course, robust data. The Department of Health is currently conducting a review of the social care data that it asks local authorities to collect. For the first time, it is considering including data on autism. That is essential to ensure that local areas have adequate data on the needs of the people with autism, so that they can plan to serve them effectively. What progress is being made on that review of social care data and including autism in those data?

To conclude, let me say a few words about three key areas: guidance, training and data. On the question of guidance, NICE's proposals to develop two quality standards on autism, along with the NICE guidelines on autism, if followed and implemented fully, will help the commissioning consortia to commission the right services for people with autism. That is certainly most welcome.

As for training, the document *Fulfilling and Rewarding Lives*, the strategy for adults with autism in England, commits the health department, working with the General Medical Council and the Postgraduate Medical Education Training Board, to ensure that autism is part of the core training for doctors. That, too, is welcome, but becomes even more urgent as GPs take on a more strategic commissioning role, if the Bill goes through as it is.

Finally, data collection and planning for people with autism is currently very poor. Only 20 per cent of joint strategic needs assessments even mention autism, let alone ensuring that services are planned through the process. We must do much better than that. One of the biggest problems that health and well-being boards and GP commissioning consortia will have will be assessing need, to obtain robust data and ensure that they are available. It is therefore crucial that data collected by those bodies must be broken down by multiple disabilities such as a child with autism, epilepsy and depression. That, in turn, needs to be supported by the NHS outcome frameworks to incentivise that and ensure that it works.

I have posed a number of questions to the Minister, and I have no doubt that he will want to discuss those with officials. I am quite happy for him to write to me later and, probably, to put a letter in the Library.

People with autism often do not have a voice. We can be that voice. We can make sure that the Government listen, understand and respond to their needs in this massive shake-up of the National Health Service. I am encouraged in this Chamber to believe that we will not let down people with autism; we will be the voice of those who do not have a voice of their own.

8.43 pm

Baroness Tyler of Enfield: My Lords, it is perhaps inevitable that NHS reform is a subject which generates a great deal of heat but, at times, it seems, precious little light. The NHS is a precious institution; it is one that binds us together; one to which most of us have a very strong emotional attachment. Perhaps like close family members, it is something that we feel that we know well and love but have seen warts and all.

I support many of the principles behind the Bill—increased patient involvement and choice, and integration between health and social care—and welcome many of the changes that the Government have made to the Bill as a result of the Future Forum's work, particularly the strengthened role of the health and well-being boards. The challenges that the NHS faces are immense. I do not need to rehearse them; many noble Lords referred to them, as did the Minister in his most eloquent opening speech. However, I particularly want to draw attention to the challenge of the scale of the health inequalities in this country, which are so often linked to public health issues.

The challenges are daunting and I have no doubt that reform is needed. I have never been one of those who thought that the NHS could simply stand still and deal with these challenges, particularly at a time when it is being asked to find £20 billion of efficiency savings. We need a fundamental change in the way that healthcare is delivered to people. I am not really talking about structures here—it is more about how those really big slugs of expenditure are used and how the decisions get taken, although of course structures influence those decisions.

At present, foundation trusts have a financial incentive to maximise their activity while GP referrals to hospital consultants do not have any impact on their own budgets. These sorts of arrangements can run counter to the efficient use of the totality of the NHS resource, particularly in chronic care cases. We need to move to a world in which community, primary and secondary care providers have a shared interest and incentive in optimising the most effective use of NHS money for the whole population. For me, in essence, this will be the key test of the success of these reforms.

Inevitably, much of the debate has focused on what I call the architecture of the NHS. This will always be complicated, given the NHS's scale and complexity, and often feels quite incomprehensible to people not involved in the subject on a daily basis—and I include myself in those numbers. I fully understand that something as huge as the NHS needs a proper management and governance structure, but I fear that much of the political debate will feel a long way removed from the reality of people's everyday lives. Arguments about cherry-picking, marketisation and commissioner/provider splits are important, but they often seem to have very little relevance if your main concern is that you cannot get an appointment with your GP—or, indeed, get on to the GP's books—are waiting for a hospital referral or for an operation or are worried about the long-term care of a family member leaving hospital who is unable to look after themselves.

What really matters to most people is the quality, timeliness, responsiveness and personalised nature of the care and that it is delivered in a way that treats them with dignity and respect, is compassionate and has human warmth. People do not want to feel as if they are going through an impersonal, one-size-fits-all sausage-machine type of health system. A lot of that has to do with culture and attitudes, workforce training and standards of clinical leadership—often things that you cannot legislate for.

I do not take a doctrinaire stance on matters of structure, but the structures must contain the right incentives to ensure not only efficiency and value for money but equitable access and outcomes. I am comfortable with a mixed economy of providers—indeed, we have had that for a number of years now in the NHS—provided that there is indeed a level playing field. We heard about this earlier in the debate.

One point that perhaps has not been made in the debate is whether there is a level playing field for charities, others in the voluntary sector and NHS providers. At the moment, in a number of respects, including on issues like how VAT is treated, there is not a level playing field. I know that many charities

[Baroness Tyler of Enfield]
feel at a distinct disadvantage. The voluntary sector plays a hugely valuable contribution to health outcomes, particularly for vulnerable groups and those with some of the most complex needs. I call upon the Minister to outline his plans for ensuring that the playing field that he talked about really is level for the voluntary sector.

I will judge the success of these reforms, and whether all the time and energy expended on them has been well placed, on whether they improve outcomes for the whole population, particularly the most needy and vulnerable, who all too often have been short-changed in the past. Noble Lords will be familiar with the statistics on health inequalities, but they are stark and bear repetition. In London, where I live, men's life expectancy ranges from 71 years in one ward in Haringey to 88 years in one ward in Kensington and Chelsea—a difference of 17 years. This underlines the absolutely critical need to put more focus on public health interventions. I welcome the establishment of Public Health England and the fact that public health functions at a local level will now sit with local authorities. However, as the Bill progresses, I hope it will be possible to strengthen still further the provisions relating to health inequalities.

Mental health is an area where I still have considerable concerns. I pay tribute to the eloquent remarks of the noble Baroness, Lady Hollins. Too often, NHS services and structures are designed around physical healthcare needs, with mental health then squeezed in as an afterthought. For example, the NHS 18-week waiting time never applied to mental health. The Bill presents an opportunity to put mental health on an equal footing with physical health, but there are worrying signs that history may repeat itself. In a world without targets the system hinges on properly designed outcome indicators, yet proper mental health outcomes have yet to be developed. Tariffs are also key to the system but mental health tariffs are still not up and running. Without those tariffs in place, I fear that commissioners will struggle to allocate appropriate budgets to mental health and will be working in what you might call a different currency from that of the physical health world, which will make integration harder.

There were other things that I should like to have said, including on children's mental health, but I do not have time to do that. I shall finish by going back to where all of this started—the central underlying principle of "No decision about me without me". A strong evidence base is building up which shows that outcomes improve where patients are actively involved in decisions about their care and treatment, not least because they are far more likely to stick to their treatment regime. However, the latest data from the national patient survey show that a large number of patients still do not feel that they are involved in those decisions. Indeed, the figures have barely improved since 2002. Research also shows that patients care more about being able to exercise choice in the type of treatment than about being able to choose between providers—that is, which hospital or GP to use. We know that patient involvement is strongly linked to health inequalities. Therefore, I ask the Minister to clarify the Government's intention in this area, so that increased patient involvement is indeed a key outcome of these reforms.

I look forward to the detailed scrutiny of the Bill in Committee to strengthen and improve it further. That is where we should now proceed without delay.

8.52 pm

Baroness Gould of Potternewton: My Lords, I, too, want to raise the question of public health, but I want to talk much more about the structures and whether it is possible, with the structures that we have, to meet the Government's commitment to focus on public health. I hope these are not just fine words and that there is a real commitment to public health. I agreed with the Minister when he said this morning that public health had received little coverage to date. For me, it is absolutely key. To quote a senior physician: "Healthcare is vital to all of us some of the time, but public health is vital to us all of the time". That is something that we should bear in mind constantly.

I support the decision that public health should return to its origins in local government for many of the reasons that other noble Lords have indicated. The local authority is best placed to influence the factors that have the biggest impact on a person's health. I genuinely want the new structure to succeed, which is why I want to raise some of my concerns about the present position. I am concerned about the fragmentation of the services, for instance the proposed split of sexual health services when integration is essential. That applies to many other services, too. I am concerned about the lack of clarity in lines of accountability and access between Public Health England, commissioning groups, the NHS, the health and well-being boards and the directors of public health. I am concerned about the lack of a definition of what constitutes public health, how it will relate to all the other key functions of local government and, not least, the inadequacy of the designated funding. It might be ring-fenced but, without a definition of what it covers, ring-fencing is meaningless. We have the concepts but not the detail, and it is the detail that we should look for in Committee.

Public Health England, an executive agency within the Department of Health and under the direct control of the Secretary of State, will oversee the operation of the public health system and manage national issues such as flu pandemics, as well as incorporating the Health Protection Agency and the National Treatment Agency for Substance Misuse. That for me raises a serious question about the independence of the staff of those two bodies, for without independence it seems impossible that they are going to be able to carry out their job in surveillance and monitoring. We really have to look seriously at whether that is the right position.

Crucial to public health are the directors of public health. They are appointed by the local authority, but in contrast to the protection afforded to other key local authority staff they have no significant protection of tenure. A local authority may terminate the appointment of the director of public health only after consultation with the Secretary of State. I would like to know what the role of the Secretary of State is. Can he overturn the decision of the local authority?

Also diminishing the role of the DPH is the lack of provisions guaranteeing the necessary resources, staffing and status to allow him or her to carry out their

important responsibilities. To be effective, they have to be senior officers who, I believe, report directly to the chief executive of the council. The Government reject the argument that DPHs and other public health officials have to be registered with an appropriate statutory body, ignoring expert advice such as that from the Royal College of Physicians, which says:

"An expert and influential Director of Public Health will be essential if a more localised system of public health is to be effective".

The Faculty of Public Health regards statutory registration as essential to ensuring the quality of the senior public health workforce and to protecting the public, as did the Future Forum and the House of Lords Select Committee on HIV and Aids. As a consequence of the Government's proposal for a voluntary system, an employer can appoint untrained and unqualified applicants to vital positions, including that of director of public health. An example of what might happen is that a voluntary registered public health specialist is on call when an emergency happens, requiring an instant decision that could be one of life or death. Surely that person must have the required expertise to take that decision and not be in a position where they might put people's lives at risk.

Key to the scrutiny of commissioning decisions as well as to the voice of the people are the health and well-being boards, which have been mentioned. At this stage, I have only one question for the Minister. Does he believe that the Bill gives these boards sufficient power to ensure that service delivery matches local needs and to take on the responsibility for producing the joint strategic needs assessment, ensuring that this is taken into account in developing commissioning plans? "Having regard", as the Bill says, does not necessarily mean acceptance or implementation.

A further point relating to the localisation of public health is the question of the national tariff. An amendment moved by the Health Minister, Simon Burns, makes it clear that unlike services commissioned by the CCGs, national tariffs will not apply to local authority or public health services. This is a particular problem for sexual health. The return to a system of block contracts will threaten the open access nature of all sexual health services and potentially restrict those able to attend services according to age or place of residence.

The London Specialised Commissioning Group has shown that commissioning on a broader basis provides efficiencies, economies of scale and uniform standards of treatment, so providing the best service for the patient and bringing it in line with the Government's stated aim of the future being patient-centred. I ask the Minister quite sincerely to examine this proposal. It is essential that there is flexibility in the tariff system.

No one would argue that the NHS does not need reform, or that there is no place for conditions in commissioning, or that the focus should not be beyond the patient, but I see no case for this distortion of the NHS on which this Bill is allegedly based. There is no democratic mandate, and no consensus for these dramatic changes, and I find it very difficult to understand how the Government can ignore the volume of concern that has been expressed about this Bill from all quarters of the health service and the public.

I must also ask the Minister about the ethics of the Government starting such a major reorganisation before the legislation is complete. It seems to be an attempt to override the parliamentary process. Both concepts of "national" and "service" are being dismantled. Those ideals are clearly of less importance than the unevidenced rationale to break up the NHS and provide incentives for the private sector. It may be that we can hear a little more in the Minister's reply about the question of competition, which we did not hear about this morning.

I ask the Government to genuinely listen, to put the NHS first and to give it the stability it needs, rather than just continuing with the dangerous limbo in which the NHS is at present. I shall support the amendments of my noble friend Lord Rea and the noble Lord, Lord Owen. There is so much to rethink. There are so many questions to answer and so many things to put right in the Bill. Supporting both or either of the amendments gives us the opportunity to do that, and I hope that we will have that opportunity.

9 pm

Lord Walton of Detchant: My Lords, as it is 66 years since I graduated in medicine, I can say with total confidence that I am the only Member of your Lordships' House who was practising medicine before the NHS came in. I can remember, as a paediatric houseman in 1945-46, seeing children admitted with perforated appendices because two penn'orth of castor oil was cheaper than the doctor. Thank goodness that after the health service came in—and I am one of its most fervent supporters—that kind of experience became something of the past.

In 1996 I was invited by the British Medical Association to give a lecture to celebrate the 50th anniversary of the passage of the NHS Act, which I was very pleased to do. I said that in those 50 years I had lived through eight reorganisations of the NHS. In the 15 years since I gave that lecture there have been nine major and minor reorganisations. No Government have ever been willing to let the people in the NHS get on with it without producing some kind of modification.

Looking back over those years, I recall that in 1974 I was dean of a medical school when Lord Joseph, as he became—he was then Sir Keith Joseph—as Secretary of State, introduced a massive reorganisation of the NHS. It was a painful experience. It was based totally on a detailed report by McKinsey management consultants that the Government at the time swallowed whole, and they created district health authorities, area health authorities and regional health authorities. The reorganisation introduced consensus management and the result was that the whole decision-making process in the NHS congealed. The reorganisation took two years to implement. It took another two years to show that it was disastrous, and another three years to get rid of it. I just want to be quite clear about the reasons why I look upon this Bill, enshrined in two enormous volumes and 300 pages, with a certain healthy scepticism—as I have done over a number of other reorganisations. Do any of your Lordships remember, much more recently, the primary care-led NHS? That was an arrangement that foundered without trace.

[Lord Walton of Detchant]

The Bill in its original form was, in my opinion, potentially dangerous and totally unacceptable. I have to say that the Future Forum under the leadership of Steve Field has produced significant improvements, but the Bill remains full of potential hazards. I know that my noble friend Lord Owen has done his best to produce an amendment that he believes would allow the possibility of making the Bill much more acceptable. I have reservations. I have not yet decided which way I shall vote, although one reason for not voting for his amendment is that I am now in my 90th year, and the delay that it would cause might make it uncertain that I would be able to contribute to the later stages. However, that is another issue that we will look at in a moment. I am going to confine myself and not talk now about the responsibilities of the Secretary of State or about competition. I am going to keep my powder dry on such issues until Committee.

Today I want to mention four things that give me particular concern. The first is commissioning. I believe that there has been a vast improvement in the standard of general practice in the UK since the introduction years ago of vocational training. I have an excellent general practitioner—he was one of my former students—and I have discussed with him this issue. He is the very first to admit that whereas he and his GP colleagues can fulfil a major role through these new commissioning groups, they do not have the expertise or knowledge to be able to fulfil the responsibilities of commissioning highly specialised services. That will fall to the national Commissioning Board.

Recently I have served on two all-party group inquiries looking at facilities across the UK for patients with neuromuscular disease and also for patients with Parkinsonism. They demonstrated a remarkable unevenness of standards of diagnostic services and of care in these specialties in different parts of the country. When these major deficiencies were drawn to the attention of the chief executives of the strategic health authorities they were so shocked that they took action to correct the problem.

I do not believe that the national Commissioning Board, as a single entity, could—however experienced, however distinguished—look after national commissioning across the entire country. It is inevitable, and I believe that David Nicholson agrees with this, that there must be not a regional—that is not an attractive word nowadays—but a sub-national component, with these individuals commissioning throughout the country, and they must be located, I hope, in relation to the so-called clinical senates which are going to be introduced. We are living in an era when genomic medicine is developing a whole series of new treatments and orphan drugs are emerging for patients with rare diseases. Some time ago it was unthought of that these diseases would be amenable to treatment. Therefore a sub-national commissioning responsibility is absolutely crucial to help to advise the national Commissioning Board on its responsibilities.

I turn now to education and training. There is nothing in the Bill at all about the crucial relationship with the universities for the undergraduate training of doctors, dentists and other healthcare professionals. That must come in. Equally, the Bill takes no real account of the fact that, ever since the NHS began, it is the statutory responsibility of the National Health Service to provide postgraduate training for doctors, nurses and dentists in specialties. That is the financial and organisational responsibility of the NHS.

There was an astonishing suggestion in the original White Paper that they were going to replace the postgraduate deans with local skills networks. This was utterly staggering and took no account of the fact that the postgraduate deans play a major role not only in appointing young doctors to their foundation posts and specialist registrar posts, but in providing the postgraduate training that is so essential for the future. Perhaps I may ask the Minister in what way these deans, with the abolition of strategic health authorities, will have the ability to make certain that foundation trusts and commissioning groups will provide the facilities that are essential for the education of these individuals. This must be in the Bill but it is not there at the moment. It is crucial that that is recognised.

Also—and I speak as a former president of the General Medical Council—under the Medical Acts the GMC has the statutory responsibility to oversee and provide high standards of medical education and to co-ordinate all phases of medical education in collaboration with the medical royal colleges and so on. The Bill is silent on that issue.

The noble Lord, Lord Willis, made an excellent speech, and so did the noble Baroness, Lady Warwick, about research. One must recognise that although there are three sentences in the Bill about the responsibility of the NHS for research, they are not enough. Today's discovery in basic medical science brings tomorrow's practical development in patient care. Years ago I chaired an inquiry into research in the NHS, which led to the Culyer report and led, eventually, to the establishment of the National Institute for Health Research. The Government of the day said that 1.5 per cent of the national health budget would be spent on research. It has never got up to more than 0.9 per cent, but nevertheless could the Minister confirm that the work being done by NIHR under the inspired leadership of Dr Sally Davies and others will be protected? Will it be made clear to commissioning groups and independent foundations trusts that they have a responsibility for research? I echo entirely what the noble Lord, Lord Willis, said about the crucial importance of accepting the report of the Academy of Medical Sciences, so expertly chaired by Sir Michael Rawlins, which will make the organisation of clinical trials, which have become so incredibly complex, very much easier. It is important that this be enshrined in the Bill.

There is so much more that I could say, but the Bill at the moment is shot full of deficiencies, ambiguities and other defects. It is incumbent on this House, with its expertise and the experience of its Members, to see this Bill through a long and detailed Committee stage to amend it and make it acceptable, in the interests of the long-suffering healthcare professionals and, above all, our patients and the British public.

9.11 pm

Baroness Royall of Blaisdon: My Lords, what a pleasure to follow the noble Lord Walton of Detchant, with his wise words, his healthy scepticism, his wealth

of experience and his staggering link with history. It is a real pleasure to be here with somebody who was here at the birth of the NHS. I find it difficult to match his mental dexterity in my 57th year, I have to say.

It may seem odd that I am speaking from the Back Benches when we have such a stellar cast on our Front Bench, but like everybody else in this Chamber, I feel passionately about the NHS and care deeply about it. For me, this is not about politics; it is about passion and principles. My resolve to speak about this Bill has been strengthened by the hundreds of letters, briefings and e-mails that we have all received from so many people up and down this country. We have a remarkable health service; we should celebrate its success. It is absolutely not broken and it is the envy of the world. That is not to say that it cannot be better; of course it can be better. But it is a fine service.

Before I begin, I must comment on the flurry of letters that have been written by the noble Earl and the Secretary of State. In the case of my noble friend Lady Jay and the noble Lord, Lord Owen, they were received far later than they should have been received, and I understand that one noble Lord among us did not receive his letter until the press had received it. I would say in passing that if that had happened under my Government we would have been slaughtered in this House by all sides, and rightly so.

I am in favour of reform, as is my party, as we clearly demonstrated when we were in government. I well understand the budgetary demands and technological advances, the increased need for health and social care and citizens' aspirations for a better health service. All these things mean that the health service cannot stand still, but it cannot be right that, while the NHS and its brilliant, dedicated staff are grappling with the huge changes that result from the Nicholson challenges, the Government are imposing a massive, destabilising, top-down reorganisation for which they have no mandate. For any reform to succeed, it has to be owned by those who work in the service, and it is clear that there are very few people working in the health service who support the profound changes being introduced by this Bill. My first question to the Minister, for whom I have the highest personal and professional regard, is to ask where the evidence is that the spending of billions of pounds on this reorganisation will work and why the Government have to do it now. Clearly the Government are following a political timetable, and I believe that this Bill is ideologically driven. It was certainly interesting to listen to the noble Baroness, Lady Jolly, when she admitted that the proposals had driven a coach and horses through the coalition agreement. Services are being cut, waiting lists are going up, nurses and doctors are tearing their hair out all over the country because they are having to make cuts and cut certain services, and they know that they cannot make any further cuts without affecting patient care. The noble Lord, Lord Clement-Jones, said that it looked as if the cuts were being made rather than resources being redeployed, and I believe that to be the case. So why are the Government now inflicting this Bill upon the health service?

My major concern, however, is about the principles which underpin this Bill, especially that relating to competition. As my noble friend Lord Darzi pointed out, free market idolatry is dangerous, and this Bill as it stands makes a free competitive market the linchpin of our NHS. That cannot be right, and it offends against the founding principles of the NHS, which have been much quoted today. Like so many noble Lords, while I am happy to be a consumer in relation to electricity and telecoms, I want to be a patient when I am ill. When my loved ones are ill I want them to receive quality care. Choice is empowering, but when my loved ones need emergency treatment, I want the ambulance to take them to the appropriate centre of excellence, where there is no question of financial transactions. Any step along the road to an American free market in health and social care is a dangerous step, a step too far, and this Bill is, I believe, a step too far.

This morning the right reverend Prelate the Bishop of Bristol mentioned his concern that some health organisations, in order to succeed in the tendering processes, might use unqualified staff, which would be cheaper. That is a real fear, and that is just one reason why I wholeheartedly agree with the noble Baroness, Lady Masham of Ilton, that Clauses 225 and 226 on regulatory bodies must be mandatory.

I want a National Health Service in which all citizens, no matter where they live, no matter what their age or income, have access to quality care, free at the point of delivery. As my noble friend Lord Darzi said, quality must be our collective purpose and common endeavour. But it must be quality for all. There are many elements in this Bill which I fear will lead to a fragmented competitive market rather than a comprehensive public service which reduces health inequalities. Despite the duty of the Secretary of State to have regard to reducing inequalities, I believe that that is too weak. Things like the removal of the patient cap will move the NHS towards a two-tier healthcare system in which private patients could jump the queue. That would exacerbate the health inequalities in our country and I also fear a post code lottery.

We were told today by the IFS that 400,000 children will fall into poverty by 2015. That will entrench the health inequalities in our society. Surely now is the time to do everything possible to ensure that in health and social care, at the very least, we are doing everything possible to minimise health inequalities.

One of the small parts of the Bill on which I will be working relates to the abolition of public bodies. The Government have of course abolished various public bodies to which the citizens of this country are very much committed, such as the Youth Justice Board and the coronial office. They have a very strong policy on public bodies and on getting rid of quangos. In spite of that, with this Bill, they are creating the biggest quango in the world and they are creating hundreds of public bodies. I would just quote a couple of comments from the noble Lord, Lord Taylor of Holbeach, in the Public Bodies Bill debate. He said:

"The landscape for public bodies needs radical reform to increase transparency and accountability".—[*Official Report*, 14/10/10; col. 622.]

He also said:

"The quango state has in the past suited both government and politicians. It has never suited the British public, who expect clarity and, as taxpayers, insist, rightly, that Ministers ensure that

[Baroness Royall of Blaisdon]
every pound the Government spend is spent efficiently and effectively".—[*Official Report*, 9/11/10; col. 64.]

I do wonder what is happening with this Bill and the various quangos that are being created.

I also wish to raise conflict of interest among GPs. I do not know whether noble Lords are aware, but quite recently it was reported that GPs at a health centre in York had written to patients saying that the NHS will no longer fund minor operations and instead they offered to carry out the procedures for a fee. This is an unprecedented step in the health service. They advised patients that for a number of minor surgical procedures, such as ingrowing toenails, mole removal and chopping out of warts and cysts, they would have to go private. This GP practice is also part of HBG Ltd, which is wholly owned by the practice. So the people who are offering private healthcare are the GPs in question. That cannot be right, and I ask the Minister to look into similar cases and for his assurance that this will not be allowed in future.

The noble Lord, Lord Willis, made a superb speech about research and development. I very much hope that the Government will take on board absolutely everything he said as I believe it is very necessary for a modern health service.

My final point is about prostate cancer, which is very dear to my heart. The Prostate Cancer Charity provided me with an excellent briefing, which I seem to have lost, in which it mentioned various things. The noble Baroness, Lady Williams, mentioned it this morning and some dreadful things that are happening in America. The Prostate Cancer Charity is concerned about the cost of reforms, the savings that are required and the fact that these might threaten clinical nurse specialist posts. I am very worried about things such as late diagnosis and will seek reassurance from the Minister that the Bill is not going to affect referral and diagnosis of conditions such as prostate cancer. My husband died because of his late referral in respect of prostate cancer and I would not want that to happen to any other man or loved one in this country. I should also add that it is common knowledge that, once he had been diagnosed, my husband received the best possible care in this country.

The NHS was established by a Labour Government in place of fear. The Conservatives voted against it at that time. This Bill has established a new climate of fear among staff and patients as it seeks to transform our National Health Service, which provides quality care, into a free market. I will be supporting my noble friend Lord Rea, but should his amendment fall, I will certainly support the amendment of the noble Lord, Lord Owen, which will not delay but will enhance the scrutiny of this very, very important Bill.

9.23 pm

Lord Monks: My Lords, I rise to make a point about good management, which I hope will be accepted as a truism throughout the House. It is a solid management principle that when you are doing something complicated and difficult, and certainly when you are doing it for the first time, you are likely to make mistakes. Excellence comes through practice, repetition and continuous improvement. It applies to surgeons, and administrators, and it should guide us through the management of the NHS.

The NHS is much improved in many respects in recent years. However, as the noble Lord, Lord Walton, made plain, it has for too long been in a state of constant change—almost death by review. The present systems were only just bedding in when this Bill was swung on the nation without inclusion in the manifestos or explicit mention at the election. Indeed, a major spasm of reorganisation is already under way, despite the fact that the Bill has not cleared this House. We have pre-emptive, premature implementation, and I am sure I am not the only one who rather thinks that this House is being taken for granted. So now it is upheaval time again: enormous costs, new systems, new contracts, new turf battles, new everything. A bonanza for the consultants, the lawyers and the logo-designers; but a nightmare for those who are going to be managing the NHS, wrestling at the same time with financial pressures, staff uncertainties and morale problems. For me, this is British public administration at its worst, lurching from review to review. The Government could have tackled the problems in the NHS in a consensual and incremental way and stopped short of volcanic change. However, pejoratively, they have rejected an approach of this kind as piecemeal and have gone instead for the big bang.

The central ideology of this big bang is that the Secretary of State is shrinking his role while expanding the role of the market. This is a profound challenge to the ethos of the NHS. It was not set up with competition as its guiding star; indeed, I doubt whether it will be any good at competing with private providers. These, I guess, will have a field day—hoovering up the profitable treatments while leaving the chronic, the difficult and the expensive for the NHS, mired as it will be in administrative and cost-cutting mayhem.

I am not surprised that the Conservative Party has embarked on this drive towards private health. It has always contained some powerful forces that do not like the NHS and yearn for the American way. However, I am surprised that the Liberal Democrats—with honourable exceptions—have so far followed the same path. As my noble friend Lady Thornton said at the start of the debate, the Liberal Party played a significant and honourable role in the formation of the welfare state through the efforts of people like Lloyd George, Keynes and Beveridge. I like to think that these titans might be spinning in their graves at their successors' current pursuit of this Bill. I hope the noble Lords on the Benches opposite—indeed, all the noble Lords on the Benches opposite— will reflect on what they are doing before it is finally too late.

9.26 pm

Lord Harris of Haringey: My Lords, at this two-thirds point in this debate, I make no apology for focusing my remarks on Part 5 of the Bill, and the quality of the voice for patients that it offers. This Bill is likely to damage irreparably the National Health Service, creating a service that is less accountable and more fragmented; that is increasingly provided by for-profit organisations; and where the relationship of trust between doctors and their patients is undermined. Under such

circumstances, an effective structure is essential to support patients in navigating their way through the new arrangements, to ensure that their needs and concerns—both individually and collectively—are not neglected in the brave new world of private suppliers feeding on the remnants of public provision. It is essential to guarantee that, with the democratic deficit that will now open up in health provision in this country, the impact of the changes is catalogued and drawn to the attention of those charged with regulating the new system, of Parliament and ultimately of the public who are paying for it.

I declare a former interest as someone who—for 12 years—was director of the Association of Community Health Councils, then the statutory body representing the interests of the public and the users of the NHS. The Government are now bringing forward another round of proposals to fill the void left by Community Health Councils when they were abolished in 2003. They were succeeded by patient and public involvement forums, which lasted four years before they were replaced by local involvement networks. Again, with a life of four years, LINks are to go, to be replaced by HealthWatch. The sequence of change in consumer organisations is a poor recommendation of the previous Government. I am shocked to see that the current Government are moving forward in a similar vein.

Of course, the Government's objectives are laudable: "No decision about me without me" is as resonant as previous rhetoric about putting the patient at the heart of the NHS or the mantras about patient empowerment 10 to 15 years ago. Some of your Lordships will even remember John Major's Patient's Charter—that daughter of the Citizen's Charter and that cousin of the Cones Hotline. How does the high-sounding rhetoric match up to the reality of this Bill? How far are patients going to be involved in decisions about managing their own care and treatment? It is simply not clear whether these are adequately safeguarded in the Bill. A duty to promote involvement or a duty to promote choice is not a sufficient guarantee. Who will hold clinical commissioning groups or the NHS Commissioning Board to account for the extent to which they have promoted that involvement or choice? Where will patients go for redress if they find that their family doctor will not refer them for treatment or investigation but insists on managing that treatment or conducting that investigation within the practice, thereby keeping the resource that would otherwise go with that patient? What will be the process for ensuring that key commissioning decisions are in line with the preferences of those affected by them and that those decisions reflect the expertise that patients have in their own conditions and the experience that patients collectively have of their local services?

Presumably we will be told that this is where HealthWatch will come in, but what will HealthWatch mean in practice? The first problem is that it is unclear how local healthwatch groups will be constituted. If individuals are simply going to be self-selected, their views, though valuable, will not necessarily be representative of all service users, and there is a risk that because of that they will not be treated by commissioning groups as having legitimacy. Members of local healthwatch groups need to have their own local accountability and must have the resources to engage with the wider community to be able to assess and represent their views.

Resources will also be necessary to enable local healthwatch groups to provide advice, support and advocacy. This will be an important and potentially substantial role in the brave new world of the NHS that this Bill creates: a world where patients will no longer be clear whether their GPs are acting in their interests or to bolster their practice's coffers; a world where decisions about what is to be commissioned will be taken with no clear system of public accountability; and a world where for-profit providers will increasingly squeeze out those that are not-for-profit and where profitable treatments will be cherry-picked.

A strong system of patient advocacy and support will be needed, but will it be provided? This will depend on the decisions of hundreds of local councils. The money provided by the Department of Health will not be ring-fenced, and there will be no mandating of local authorities about the nature and quality of HealthWatch services that should be supported. All this is in the name of localism, that same localism that has seen the budgets of LINks drop dramatically this year, in some instances by more than 50 per cent, despite, as the Minister told a number of us last night, the Department of Health saying that it has increased the resources available. The resources went up, but the resources available for local healthwatch went down. It is a localism that means that the Minister can offer us no assurances that those advocacy services that he promises us will be adequate. In future spending rounds who will argue with the Treasury for the moneys for HealthWatch? Will it be the Department of Health, which will have no say in whether the services expected are being delivered, or DCLG, which will have no interest in those services, or will the current commitment be allowed to wither on the vine as no department fights its corner?

Is it even appropriate that local healthwatch groups should be resourced via local authorities which themselves will have responsibilities for social care provision? Is there not a potential or perceived conflict of interest here? How comfortable will a local healthwatch group be in criticising its paymasters about the quality of that provision?

Finally, there is the relationship with national HealthWatch. A national structure is essential for the views and concerns of local healthwatch groups to be captured and articulated at national level, but that national structure must grow from and be a creature of the local groups, not sit above them as a mere sub-committee of a regulator, moreover a regulator to which requests for action and even criticism may need to be directed by that structure.

The new NHS will need a strong and independent user voice. The Government keep citing the proposals on HealthWatch as evidence not only that such a voice will exist but that the patient will indeed be central to the myriad new structures that they are proposing.

Yet the danger is that what we are being offered is no more than a fig-leaf whose own legitimacy will be flimsy, a fig-leaf whose resources will be plundered as local government itself faces a future with rapidly

[Lord Harris of Haringey]
dwindling money, a fig-leaf whose independence is compromised by its relationship with a paymaster whose provision it is supposed to be monitoring, and, above all, a fig-leaf protecting the nakedness and insufficiency of the protestations that no decisions about the patient will be taken without him or her. My Lords, it is just not good enough.

9.35 pm

Lord Cotter: My Lords, today we have had the chance to debate just about the most important subject for the people of this country that could be facing us—health.

I pay tribute at this stage to those who work in the health service and who put their heart and soul into caring for us and our families. I also thank the many people in the health service who have sent us information about their concerns with and practical experiences of the health service, as well as their concerns about the treatment that they will receive in the future. It is easy to dismiss such information as lobbying. I do not see it as that; I think that we can make a judgment about what is and is not relevant. However, it has been very important for this debate to have received so much information from our own parts of the country, as well as nationally, about how people feel and about their concerns with what we are now addressing. We are also at a time when morale among staff in the health service is extremely low. That is the message that I get from them. Many people are waiting for the results of this Bill with some trepidation.

Regardless of going into the detail of the proposals, I wonder whether such detailed changes are right at this time—perhaps at any time—when we are so short of the money that is required to implement the measures. I liken it to throwing all the balls in the air and hoping that they will land the right way. I do not want to be too negative or at this late hour to repeat too much of what has already been said. However, there are worries about competition. Is it really the case that providers can be fined a considerable figure if they are not seen to be competing enough? How is that to be assessed? Competition in what way?

One of the big commitments of the coalition Government is to reduce red tape and bureaucracy in this country. That is good but, with all the myriad bodies that are being created to implement the Bill, are we sure that we are not adding more bureaucracy rather than having less? It has been suggested that the number of quangos will increase from 163 to more than 500. Is that so? If it is, is not the complexity, bureaucracy and red tape that that could create a matter of concern? It is of course necessary to have regulation but we need to be careful that it is the right sort of regulation.

The role of the Secretary of State has been raised more than once, having been put into question or, at least, been questioned. I am sure that the Minister will be able to provide an assurance in this area, because this is seen as a crucial point to be addressed.

Another point that has arisen in the debate today and has also been in evidence for a while, and on which we need clarification, is the situation regarding untrained health workers or healthcare assistants. Will they be covered by a voluntary register or, better still, have a binding code of conduct? This will give reassurance and perhaps raise the standards that we expect to receive from the health service.

For the 15 years or so that I have been in Parliament, I have been aware of the need for all Bills to have strong impact assessments. I remember in about 1998 or 1999 thinking that quite a lot of Bills which were not adequately supported by impact assessments were going through Parliament and, over time, that has been proved to be so. However, I have seen it expressed that the impact assessment associated with this Bill is perhaps not sufficient to cover all the different changes that will take place. I would be interested to hear from the Minister whether that is so.

It is late at night, but I would like to turn to a personal point. I hope that we can all consider the health service in respect of the alternative health sector. I have gained very much from being treated by Chinese medicine, acupuncture and herbal treatments, as have a number of members of my family. I know that acupuncture has been discussed quite a lot but not so many years ago it was dismissed out of hand as some sort of quaint treatment, which has not proved to be the case. Recently, I opened the World Congress of Chinese Medicine in London, and I was asked to speak as I have an interest in the subject. I stayed for a good part of the day and it was absolutely clear how much scientific work has been done to assess and to show that there are clear improvements to be had from acupuncture.

I have also gained very much from herbal treatments. My experience with alternative medicine is that you get a quick diagnosis and treatment on the same day. The experience of my friends and family is that the assessment is often very good and getting treatment right away is, of course, so vital and can result in improvement in people's health much quicker than perhaps happens in the health service. I do not want to be too critical but when you go to a GP, they can be a bit puzzled about your condition and eventually they say after a month of trying this and that, "I will send you to a consultant". But time collapses and my experience with the alternative medicine sector, particularly with Chinese medicine, is that it is very good in that respect. I throw this point out to the Minister to see whether we can formalise it for the future.

I have repeated some of the points that have been made during the debate, which has clearly indicated that there is much work to be done to address fears and concerns and, if necessary, to make corrections to the Bill. We have a big job and a big responsibility ahead of us to ensure that we in this House check the legislation and ensure that the NHS is safe in our hands.

9.43 pm

Baroness Hughes of Stretford: My Lords, the noble Baroness, Lady Tyler, among other noble Lords, referred to the fact that the Bill and the debate have, perhaps necessarily, been predominantly about structures, pathways and commissioning boards, which are all very important, but I want to focus on people and specifically on

children and young people. I believe that whatever is left of the Bill, after this process of scrutiny and its passage through the Houses, it is vital that we take the opportunity, in so far as we can, to improve prospects for children and young people. I say that for several reasons.

First, despite there being many dedicated health professionals, the health system has often not worked well for children and young people. I know from when I was Minister for Children that the NHS, certainly at its top levels, has been very resistant to including indicators for the improvement of outcomes for children. Sir Ian Kennedy in his report last year said that many professionals feel that services for children and young people have traditionally had a low priority in the health service and that fewer resources have been allocated by the NHS nationally, regionally and locally to children's health services. The system does not always respond well to children whose needs are complex and who require good integration between health and other services. That is the case particularly in respect of disabled and looked-after children. In addition, meeting children's and young persons' needs often requires joint commissioning of all services for children—health alongside social care, education, statutory and voluntary organisations, and those speaking for and working with families.

Secondly, we have to consider that current social and economic events will have an adverse impact on children's health, and we can expect their health needs to rise. With rising unemployment, we can expect a rise in child poverty and mental illness among parents. The IFS report published today states that families are suffering an "unprecedented collapse" in living standards. Welfare benefit changes will reduce the incomes of the poorest families, affecting their nutrition and well-being. We are seeing key services such as Sure Start centres and parenting support being lost. All this, as we know from the past, will have an adverse effect on children's health. In addition, the Bill threatens to disrupt existing child protection mechanisms and the relationships between organisations working together to safeguard children.

Thirdly, the Government stress their aim to put patients and public views at the centre of commissioning, yet there are very few mechanisms for children and young people to influence the commissioning and delivery of health services. Research by the National Children's Bureau published recently shows that existing structures for patient consultation, the local involvement networks, are struggling to register children's voices. Any new mechanisms to involve local people in determining health needs must include children and young people from the outset.

Above all, the Bill makes no specific reference to children and young people and, perhaps more importantly, nor has discourse from the government Benches. That commentary has not signalled the need for the reforms to work better for children. I want many changes to be made to the Bill to ensure that the system works better for children and young people. I shall restrict my comments to the Minister to five issues. Although I relate those issues to children and young people, they arise from endemic flaws in the Bill and will therefore have an impact on other groups of patients.

First, how do the Government propose to ensure that children and young persons' health is given high priority in commissioning? Will the Minister consider amending Clause 20 so that the Secretary of State's mandate to the NHS Commissioning Board must include priorities for children's health and for reducing health inequalities between children? There is also a need to focus on reducing health inequalities at the local level. Will the Minister also consider placing a duty on the health and well-being boards and the clinical commissioning groups to reduce health inequalities particularly among children?

Secondly, the proposals for commissioning, as I have mentioned, have serious implications for the co-ordination of health and social care responses to child protection. The Government's current proposals split responsibility across three bodies: the NHS Commissioning Board for primary care, the clinical commissioning groups for acute mental health and maternity care, and the health and well-being boards for early years. Where will the clinical lead and the accountability for child protection lie? How will the Secretary of State ensure that every local area has robust and transparent arrangements for child protection?

Thirdly, the Government's proposals significantly increase the complexity and bureaucracy of the health system, as my noble friends Lord Hutton and Lady Armstrong of Hill Top have pointed out, with many more organisations responsible for different aspects of commissioning and monitoring. Different services will be commissioned at different levels—the NHS Commissioning Board, clinical commissioning groups, larger consortia of commissioners and local authorities. Children at risk, looked-after children, disabled children and those with complex needs will require packages of services drawn from all these levels and from social care and education. Will the Minister set out how these services will be integrated locally? What role will the health and well-being boards play in establishing a local framework for integration? The Bill, even after amendment in the other place, seems to imply that this is an optional part of the remit for the health and well-being boards and of the scope of the joint health and well-being strategy. The remit for integration seems to be optional. Will the Minister agree to amend Clauses 192 and 197 so that this is rectified?

Certain groups of children, for example looked-after children, care leavers and Gypsy, Roma and Traveller children in particular, are often particularly vulnerable to health problems and are also more likely to move across local authority boundaries. Will the Minister say specifically how he will ensure that the needs of these children and young people do not fall between the cracks of what I believe will be a more fragmented system, with a greater lack of coterminosity, as my noble friend Lady Royall has pointed out, than before?

How will the Minister ensure that the voices of children and young people are given strong recognition and clear ways to express themselves within the system? The Government talk much about giving patients and the public greater influence over decisions about healthcare, but there is no mention of children and young people. Local healthwatch organisations and HealthWatch England must be required to have specific and dedicated child-friendly ways in which the views

[Baroness Hughes of Stretford]
of children and young people can be elicited and acted on. Will the Minister amend the Bill so that this is an explicit requirement on local and national healthwatch organisations?

I look forward to the Minister's reply and to pursuing these issues further in Committee.

9.52 pm

Lord Ramsbotham: My Lords, like other noble Lords I have received an incredible number of e-mails and letters about the Bill. I suspect, too, that like many other noble Lords, as I listened to the reasoned case for the Bill put forward this morning by the Minister with his customary skill and courtesy, I could be forgiven for wondering what all the fuss was about. However, when like my noble friend Lady O'Loan I thought through the list of those who had written to me, I reflected that the vast majority are either patients or practitioners. What they have to say confirms the concern of the noble Baroness, Lady Williams of Crosby, that the Government have not yet made the case for the Bill with the public, and in particular with the two groups of people whose best interests are, they claim, paramount in the provision of health and social care.

Many noble Lords have rightly concentrated on concerns about competition and the position of the Secretary of State. However, like my noble friends Lord Walton and Lord Kakkar, I do not believe that these should be hived off to a Select Committee, mirroring committee practice in the other place. Far better that in order to do justice to the concerns that have been voiced to us and to exploit the undisputed expertise that has been deployed already, and will I am sure continue to be so, all aspects of the Bill should be debated in detail on the Floor of the House, however long that takes.

Rather than repeat what others have said, I intend to concentrate on three what may seem more prosaic matters in the time available. All have common NHS involvement in announced policies of other ministries about whose achievement I am now uncertain in the context of the Bill.

Noble Lords will not be surprised that having, as Chief Inspector of Prisons, proposed in 1996 that the NHS should be made responsible for prison healthcare, I should start with that. At the same time, I expressed the view that prison healthcare was a public health issue because almost all prisoners will be released and the state of their mental and physical health at that time is a matter of public interest. Furthermore, imprisonment provides an opportunity for the identification and initial treatment of mental and physical health problems that can be continued in the community in the form of aftercare.

I am very glad that the NHS has been responsible for the provision of prison healthcare since 2004, and that there is now a director of offender health in the Department of Health who has a seat on the board of NOMS in the Ministry of Justice. I am also glad to see in Clause 12, which requires the commissioning board,

"to arrange, to such an extent as it considers necessary to meet all reasonable requirements and, for the provision as part of the health service of",

in new paragraph (c),

"services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description".

However, I do not think that that definition is precise enough, and I shall be tabling amendments to flesh it out to include responsibility for those in immigration detention, secure children's homes and police custody.

I include the police in connection with the provision of another aspect of offender healthcare that I shall seek to flesh out: the diversion from prison of those with mental health problems. Psychiatric morbidity is a huge problem in our prisons; the Office for National Statistics proves that. In addition to the 500 prisoners per year who qualify for sectioning under the Mental Health Act, 70 per cent suffer from a least one personality disorder. Under the previous Government, the noble Lord, Lord Bradley, wrote a report making practical recommendations for diversion, but implementation is still in the early stages. As diversion begins at police stations, it is important that there is adequate health care provision to make it possible. I assume that that will be a matter for both commissioning and health and well-being boards.

Not all offenders are sentenced to expensive imprisonment. At the heart of the Government's proposals for reducing prison numbers are improved community sentences conducted by the probation service as credible alternatives. There is absolutely no reason why such sentences should not include the same identification and treatment of mental and physical health problems as in prison, but, at present, locally delivered probation lacks the healthcare provision that exists in local authority youth offender teams. I shall therefore be tabling amendments to rectify that, in line with Clause 191(2)(g), which states that health and well-being boards must consist of,

"such other persons, or representatives of such other persons, as the local authority thinks appropriate".

I move on to education. I have lost count of the number of times that I have raised the issue of communication skills, or the lack of them, which is the scourge of the 21st century, on the Floor of this House. In the current Education Bill, which has just completed its passage through Grand Committee, I tabled amendments calling for the communication abilities of all children to be assessed before they begin primary school, to enable them to engage with their teachers. I proposed the same in a number of education, welfare and justice Bills under the previous Government. They were followed by announced intentions to do something, but nothing has happened, except in Northern Ireland, where the NHS now assesses every child at the age of two. Similar provision in England and Wales is dogged by the fact that because speech and language therapists belong to the NHS and are funded by individual primary care trusts, no other ministry will fund their provision. The end result is that the future of countless young people in this country is being unnecessarily blighted, and I shall be tabling amendments to ensure that such provision is debated in detail.

Finally, I raise a mental health issue connected with the Armed Forces covenant and the treatment of serving and retired service men and women, as well as provision in the community, which touches on many

issues to do with regulation. I will not bore the House with details of the problems over the treatment of post-traumatic stress disorder caused by the narrowness of NICE guidelines, which preclude the loose use of alternative therapies, but I believe that it is confusing for Clause 225 to provide for both the professional standards authority for health and social care and the proposed health and social care council each to run voluntary registers for unregulated health professionals, such as psychotherapists and councillors. I shall be tabling amendments accordingly.

There is a great deal of work to be done on the Bill. I sympathise with the Minister on his impending workload, but he starts with one overwhelming advantage; he enjoys the respect and trust of the whole House.

10 pm

Baroness Massey of Darwen: My Lords, I rise humbly after so many excellent speeches and after so much expertise has been expressed. I shall raise some issues about public health and then speak about my concerns on child health in this Bill, following my noble friend Lady Hughes. I agree with her about the lack of discourse about children's health generally and the importance of integrating systems to deal with children.

On public health, I declare an interest as chair of the National Treatment Agency for Substance Misuse, the NTA, an organisation that will become part of Public Health England. I pay tribute to the Minister for his consideration, sympathy and astuteness regarding negotiations about arm's-length bodies. He has an unenviable task and I admire him for his work on it.

There are issues around the future of public health in relation not only to drugs but to alcohol, HIV, sexual health and other services. I am proud that the NTA has contributed to the improvement of drug services. The number of people in treatment has more than doubled in 10 years, waiting times are now very short and the use of opiates and crack has gone down, as research has recently shown. Service users have been significantly involved in the development of services. It has been shown that for every £1 spent on treatment for drug use, at least £7 is ultimately saved.

The Minister spoke, many hours ago now, about the importance of outcomes in health. Here we have an example of positive outcomes that could be built on in relation to public health. The improvements that we have seen are due to a strong focus on drugs as a problem for crime and health and to the appropriate ring-fenced funding over the past 10 years. Structures are in place, collaboration between agencies is notable and I like to think that the assistance of clients into recovery will continue to improve. They will not do so, though, without attention to many of the issues raised here today, including just now by the noble Lord, Lord Ramsbotham, who will be a very busy person with all those amendments.

My concerns are around the role of clinical commissioning groups and how they will engage with health and well-being boards; about the integration of health and social care for areas like drugs, alcohol and sexual health, where there is potential for fragmentation; and about the accountability of the NHS Commissioning Board for effective integrated care. I hope that the Minister will address some of these issues.

I begin my concerns about child health with the concerns of many children's organisations that the Bill must deliver for children and young people and that child health must be given the priority it deserves. I declare another interest as chair of the All-Party Parliamentary Group for Children. Sir Ian Kennedy's report last year has already been mentioned by my noble friend Lady Hughes. Children comprise 22 per cent of the population, and children are often helpless in the face of the actions of others—for example, in passive smoking. A report today raises the potential problem of the increase in relative child poverty, which, according to the report, will affect about one-quarter of all young people. I worry about the interaction between poverty and health, and I worry about the invisibility of children in health services.

We know that Graham Allen, in his recent report on early intervention, expressed the view that early intervention in social and intellectual development is vital if children are to develop positively. The same is true of health interventions. There is a great deal of evidence to show that encouraging good physical and mental health at an early age is vital to future well-being.

I shall quickly make three basic points. First, the voice of the child must be heard. Children must have a say in decisions about local services and care, as recommended by the NHS Future Forum. HealthWatch England and local HealthWatch must be instrumental in this. Secondly, local services for children must be integrated and must talk to each other. We have already seen the disastrous effects of the lack of such integration. The clinical commissioning groups, whose boundaries do not align with local authorities, must set out how effective partnerships will be developed to promote child well-being. Thirdly, surely young people with complex needs may well fall through the gaps between services as they move into adulthood. Universal services, specialist services and services for parents, families and children must connect with each other to ensure that there is a clear pathway for individuals throughout life.

Coalitions of organisations concerned for the welfare of children agree that the Bill must be amended. For example, in Clause 20, as my noble friend mentioned, priorities for improving child health services should be included in the mandate to the NHS Commissioning Board. In Clause 192, health and well-being boards must, rather than may, encourage integrated planning and delivery across health and social care services. In Clause 190, the joint health and well-being strategy must, rather than may, include a statement on how health and social care services could be better integrated with health-related services. Local HealthWatch organisations must promote the involvement of children and young people. There must be clear accountability for promoting the health and well-being of looked-after children and care leavers within new structures. Clause 162 would abolish the private patient cap, meaning that hospitals could treat any number of private patients. This could be detrimental to NHS patients and disadvantageous to low-income families and children.

Plans for involving the voluntary sector and communities must be clarified. We are all indebted to the voluntary sector for all its sterling work with children and other aspects of community life. The

[Baroness Massey of Darwen]
Royal College of Paediatrics and Child Health recommends that Clause 191 on the membership of health and well-being boards should designate professionals who are responsible for safeguarding. It also recommends that, in Clause 23, proposed new Section 14V should be amended to include maltreatment, not just the prevention, diagnosis and treatment of illness.

We shall of course return to these issues. However, I plead with the Government to take child health very seriously. Early intervention and preventive strategies are not only humane and contribute to lifelong well-being, they have economic advantages that should surely be a consideration.

10.08 pm

Viscount Eccles: My Lords, it is a great pleasure to follow the noble Baroness, Lady Massey. My interests are somewhat different. I declare that for many years I have worked with the Hospital for Tropical Diseases. I first got involved in helping to move the hospital from St Pancras. We created a small fundraising group to raise 50 per cent of the cost of the move. What convinced me that we should support the move was asking the chief nurse what she thought. She said, "I'm fed up with humping bottles of oxygen around the hospital when everybody else seems to get it delivered in a pipe". That was an example of necessary modernisation and the front line knowing what it needed.

I shall make only one more comment about the Hospital for Tropical Diseases. In its clinical faculty there is an expert on leprosy. Your Lordships might not think that it is necessary for the National Health Service to know a great deal about leprosy. However, there are some lepers in this country. That speciality is very important and, in the context of such a large organisation, it is always possible that it could be forgotten. That should not happen. I should declare that I am chairman of a small charitable trust, the Hospital for Tropical Diseases Foundation. That hospital is 200 years old. Arguably the start of the Health Service goes back about 90 years. In 1918, the Cavendish lectures were delivered and the theme was:

"The best means for preserving health and curing disease should be available for every citizen by right, not by favour".

The speaker went on to say:

"I venture to think that this will be an article of faith for every political party".

That was in 1918. It would be wonderful if we could agree that there is no dispute or disagreement about the themes of that speaker 90 years ago. There followed a 25-year gap between that, not unconnected with the financial difficulties of the 1920s, and Beveridge. As your Lordships will remember, Beveridge connected want, disease, ignorance, squalor and idleness directly to health. His report was rapidly accepted by the coalition Government of the day.

In 1944 there was the White Paper—it is remarkable that this was happening in the middle of the Second World War—in which it was generally assumed that there would be around 30 area integrated health authorities. However, that was not the decision of the post-war Government. They opted for something more centralised. We should leave it to history to judge whether it would have been better to follow the prescription of the 1944 White Paper or whether what was decided was better. We should live with the decision and not refight those battles.

The progress in medicine in this country since then has been driven mostly by international western research and development. It is important to remember how open the exchange of information is in the western world on these matters. It has also been driven by brilliant engineering. If we think of what it was like to go to the dentist when we were young and think of it now, the development by engineers of drills over that period has been quite amazing. This progress, from research and development and from engineering, will continue, and everybody expects that it will continue. The question that then arises is how significant are the detailed statutory arrangements that we make in order to back up, control and perhaps regulate this progress. Are these statutory arrangements more than enabling mechanisms, or are they possibly disabling mechanisms? Will not the progress continue, whatever the statutes say? I think that it will.

Whatever any Government thought about statutory arrangements, if they went into an election having made what the public considered to be serious mistakes about the Health Service, they would pay the penalty. I am not sure that we should spend too much time in the face of legitimate democratic expectations worrying about the constitution committees and thoughts on the role of the Secretary of State. I feel sure that these matters can be satisfactorily resolved in Committee and on Report.

Secondly, in some of the representations that we have all received, particularly those from expert bodies, the opportunities for progress, which has already taken place, are seen to outweigh politics, either internal to the NHS or external. However, for others it is not so. Some people seem to oppose change, perhaps any change. My conclusion is that in total the representations tell us that this is a serious Bill that needs serious debate and scrutiny without delay. Many serious matters need debate—for example, reducing inequalities, the balance between general practice and the many other services, the balance of resources between prevention and cure, anti-competitive behaviour, and many other matters. Nevertheless, what the Bill needs now is scrutiny and improvement, and I look forward to Committee.

10.16 pm

Lord MacKenzie of Culkein: My Lords, I will try to concentrate on some of the issues that are of concern to me about healthcare and the Bill. First, I should make it clear that my interest in healthcare derives from my being, until nine years or so ago, on the register of general nurses. However, despite being too old to be still registered, it is a truism to say that once a nurse, always a nurse.

I have spent most of my working lifetime defending the health service. I am not going to stand here tonight and pretend that all is perfect, when clearly that could not be the case. There is room for improvement and that can and should be made. That means that sometimes reorganisation might be necessary. Structures cannot be preserved in aspic for ever. However, the NHS has

rarely had long periods without organisational change. How often have we heard the cry that the National Health Service needs stability rather than this constant cycle of change that brings ever more cost, usually more bureaucracy, lots of redundancy for senior skilled staff and much more unsettlement for employees?

I have seen more reports and reorganisations than I care to remember. I begin with the Salmon report on nursing. I am not going to read the others that I have on my list. The noble Lord, Lord Walton of Detchant, has already dealt with some of them, and he beautifully demolished the 1974 reorganisation of the National Health Service which, I recall, was accompanied by the dreaded Grey Book. I will resist listing the reorganisations.

We have also had quite a lot of change in the past few years, and some of that has been good. Despite what has been said about productivity in the National Health Service in recent years, I contend, for example, that the ending of two-year waiting lists, the ending of patients lying for hours and sometimes days on trolleys, the cancer targets, the cardiac targets, the stroke targets and the new buildings have led to better patient experience and outcomes. There are now signs that we are starting to go backwards, certainly at least in terms of waiting times.

Like many, I might have been prepared to give the Bill a fairer wind had it not been for the promises before the election that were largely replicated in the coalition agreement to the effect that there were to be no more wasteful top-down reorganisations. It is not a case of a Government coming to power and looking at the books, which is the usual excuse. One might be forgiven for suspecting that this is a deliberate ploy to tell the electorate one thing while planning to do precisely the opposite.

Of course the Secretary of State in the health department should not be micromanaging the National Health Service. As I see it this Bill will allow Governments to wash their hands and absolve themselves of any responsibility from any inconvenient questions or issues on healthcare and to blame some of the new quangos the Bill will set up. The powerful speech of the noble Lord, Lord Owen, gave a perfect example here. What if there was to be a pandemic? I would hate to be the Secretary of State who tried to say, "It is nothing to do with us—it is a matter for the chairman of a quango".

It is not unusual for change to be resisted but leadership is about taking the public with one. In the case of this Bill it is also about taking employees and importantly the many professions with one as well. It is all too easy and too convenient to suggest that persons who fail to agree are motivated merely by self-interest. I do not include the noble Earl the Minister in this—I have never heard him say a disparaging word about health staff in all the time I have known him in this House—but some spokespersons for the party opposite should be more careful than to resort to the lazy argument that, for example, the 4,000-plus public health specialists were either politically motivated or too idle to read and understand the round robin before signing it. That is not the way to influence debate and it is not the way to make friends. It is crass and insulting.

I want to deal with one or two aspects of the delivery of hospital care. I had the unenviable experience fairly recently of observing that at pretty close hand. As a result of a catastrophic error during laparoscopic surgery I spent almost six months in four hospitals rather than the one night which had been anticipated. As a former deliverer of care I was on the receiving end and a rather fascinated observer. The specialist surgical team who, I guess, saved my life once the original error was recognised were superb, as were the colleagues who carried out the follow-up surgery some three months later. They were pretty special to be able to make any restorative surgery at all.

I felt safe when I was in intensive care and high dependency. The staffing levels were great, the skill mix was right and the medical, nursing and physiotherapy staff could not be faulted. However, as I later moved from ward to ward and hospital to hospital I took rather a different view. I am not going to join the noble Lord, Lord Waddington, in his general criticisms of nursing staff. I know that nursing has moved on and the patient profile is vastly different and very many skills and interventions are different because of the advances in medicines and surgery. However, some of the skill sets are the same as when I was nursing, particularly the issue of essential care. Somewhere along the line this has been lost and the status of what we used to call basic nursing is, I fear, no longer there. I am not sure whether this is due to nurse education, the nature of the structures in which nursing care is now delivered or whether it is a cultural matter, but it is one of the issues that needs to be addressed and it is not anything to do with overseas nursing staff, which was being suggested by the noble Lord, Lord Waddington.

Overstretch is a particular problem but one of the real problems is skill mix. Far too often the ratio of registered nurse to healthcare support worker is not right. Healthcare assistants are often left to carry out procedures for which they are not properly prepared or mentored. I support what the noble Baroness, Lady Emerton, said about mandated staffing levels and ratios. Ward sisters and charge nurses are understandably and clearly not doing the same job as when I was nursing. There are some really good exceptions but there is not enough evidence, in my view, of clinical leadership. It is right that the ward sister has a wider role than just getting sleeves rolled up on the ward, but there needs to be a better balance. It is not a return to the matron that we need—it is a return to the authority and to the clinical leadership of the sister or charge nurse. Patients deserve competent and compassionate care.

I was out of the country when the chief executive of the Royal College of Nursing said some nurses were not up to the mark so I missed most of that debate. Like Peter Carter, my job was to defend nurses and nursing and I have no doubt that if I had said the same things I would have been roundly criticised by some of my members and I suspect that Dr Carter was as well. However, we have to be honest. If we are concerned about the nursing profession and about patients we have to admit that not all nurses are up to the mark. I am intrigued by the plans of the Heart of England NHS Foundation Trust to trial quite a different mix of

[Lord MacKenzie of Culkein]
university education and hands-on training. I wish that trial well, because it has the possibility to meet some of the issues about which I am concerned.

My old union, the Confederation of Health Service Employees, always argued for a qualified service. Many people would think that that was a bit optimistic and pie in the sky, but we supported Project 2000 and the drive to university education, rather than just nurse training. But we always wanted support workers, whatever their job titles, to be trained and regulated; that was not at the time supported by other nurses' organisations because there was a fear that we were trying to replicate the enrolled nurse. That was not so, but there is now a widespread recognition that the public will be and must be better protected by regulation. The present training of healthcare assistants is variable in quantity and quality, yet nursing tasks are routinely delegated. I realise that there are many job titles and many different roles carried out by support workers, but there is a solid case for regulation, and it must be mandatory regulation rather than voluntary.

I shall touch on one other area in which I think that the Bill is deficient—in the commissioning for persons with less common conditions. I refer, for example, to patients with neurological conditions such as motor neurone disease. My closest friend lived with, and subsequently died from, motor neurone disease, and I have seen that ghastly condition at close quarters. Most GPs will perhaps see one case in a working lifetime, and most nurses will never see it. I never saw one in practice, although I have nursed other distressing neurological conditions such as Huntingdon's syndrome. The concern is that CCGs covering a small population and working in isolation are less likely to be able to deliver the service for patients in this category. I am advised that effective commissioning will need a population size of a quarter of a million for many neurological conditions, and much more like half a million for motor neurone disease. In the latter case, for example, a half a million population would have about 30 people suffering from motor neurone disease. How is it planned that people with less common conditions can have access to the healthcare required? Will the CCGs have a duty to work together to commission those groups? How will that be reflected in the Bill and how will the commissioning board enforce commissioning for those services if CCGs fail to work together? Will there be an advisory group for neurological conditions within the commissioning board?

We have a problem already with some of the CCGs. There are going to be no PCTs, as the coalition agreement said, to act as champions for people with residual services or less common conditions. I am told that in one area of the country there are now seven CCGs but presently one PCT. The charity Parkinson's UK has already agreed with one of the CCGs that there is a need for a specialist nurse; so far, so good, but instead of working together the CCG concerned has already told Parkinson's UK that it is up to it to convince the other CCGs for the need for a specialist nurse. So much for collaboration. I hope that the Minister can tell us that this is not going to be the pattern that many of us fear.

It is difficult for me to wish this Bill a fair wind as it stands; there is going to have to be major change as it proceeds through this place, and I look forward to much of that.

10.28 pm

Baroness Barker: My Lords, I have never been the 73rd speaker in a debate in your Lordships' House before, but that is because I have never spoken about reform of the House of Lords or hunting. I have watched people who have spoken at spot number 73, and at this time of night it is not about great oratory; it is about making four or five key points that point up major issues of the Bill. That is what I am going to do.

Several hours ago, the noble Earl, Lord Howe, set out his eloquent introduction to the reasoning behind the Bill. He talked, as did the noble Baroness, Lady Thornton, about the antecedents to the Bill—not many of the Bills debated in this House during the time of the Labour Government, as she said. One of the key antecedents to this Bill was the Wanless report of 2004, a piece of work remarkable for its depth and detail. In essence it said three things. The first was that whatever the level of resources we give to the NHS, we will never ever be able to meet demand fully. It went on to say that the long-term viability of an NHS that is free at the point of need depends on two things in particular: the extent to which the public are engaged in protecting their own health and the extent to which clinicians are involved in decision-making and innovation.

The Wanless report informed much of the work of the noble Lord, Lord Darzi—the work on the NHS constitution, for example. That, in turn, has formed some of the building blocks of this legislation. In so far as it does, I welcome some of it. Like other noble Lords who have spoken from these Benches, I welcome some of the things in the Bill. Health and well-being boards and the integration of public health and local government are long overdue. Just as Derek Wanless said all those years ago, there are very many determinants of health, the answers to which lie outwith the scope of the NHS, and they always will. That is an important achievement which is in this Bill as the result of work by some of my Liberal Democrat colleagues.

However, there are a number of issues on which I and my colleagues, notwithstanding the work of some of my colleagues down the other end, remain to be convinced. Much has already been said on the Secretary of State's duties and accountability. There is a key question which I think every person in the land wishes to be able to answer. Who is ultimately responsible for my local health service, and if it is poor, who is responsible for sorting it out? Some people may be forgiven for thinking that at the moment there is an easy answer to that question. Very often there is not an answer at all, and very often if there is an answer, the answer is "the Secretary of State". That, I am afraid, is not an acceptable way to go forward for much of our health service.

I listened very carefully to the comments of the noble Lord, Lord Owen, and I agree with him: it is inconceivable that in extremis the Secretary of State could not take emergency and urgent powers to order the NHS to cope with something like a pandemic. The truth is that most of the time the NHS is not working

in extremis—it is working on day to day health. The issue identified by my noble friend Lord Marks in the Bill is the duty of the Secretary of State to promote autonomy. Those two things are incompatible. We need to assess the duty of the Secretary of State, as the noble Earl, Lord Howe, said this morning, as part of a long chain of responsibility, from the NHS Commissioning Board, through Monitor, to clinical commissioning groups.

I want to ask the Minister a key question. In what circumstances will departmental Ministers be obliged to answer detailed questions in Parliament on the performance of NHS commissioners and providers, and what will be the nature of any direct lines of accountability between Parliament, the NHS Commissioning Board, and Monitor? The accountability of the NHS Commissioning Board is a matter of great concern to me. The idea of an independent board was one which surfaced as Conservative policy in, I think, 2007. It was very much favoured by a number of the health think tanks at the time and then disappeared without trace until it re-emerged after the election. Now it is in this Bill, but there are a great many questions of detail which still need to be answered. Its accountability to the public, given that it has extensive powers, needs to come under much greater scrutiny than is currently planned. I should like to know whether the Commissioning Board will be subject to the same standards of accountability as clinical commissioning groups. The Commissioning Board will also be responsible for holding commissioning groups to account for their performance. It will do so with reference to quality outcomes, commissioning guidance and the commissioning outcomes framework. Can the Government say how the board itself will be held to account for the quality of its own commissioning? By whom will it be held to account?

There has been an awful lot of talk today about competition. Much of it, I think, has been slightly off the mark. I think it is now true that any qualifying provider will be limited to those areas where there is a national or local tariff, ensuring that competition is based on quality, not on price. I am sorry that a number of noble Lords are not present. I would say to the noble Baroness, Lady Jay of Paddington, who quoted the example in Surrey, and to the noble Baroness, Lady Royall, that the examples they gave of services being tendered out are happening under the current legislation and are being done on price alone. That is unacceptable. In the course of our deliberations on this Bill, I think we should go back and take out some of the stuff that was introduced by previous Labour Ministers, which favoured private sector providers. That was absolutely unacceptable. If we have to have competition, I want to see it on quality of outcomes. However, I say to noble Lords that it is not the issue of competition law, but the issue of procurement law that we really need to scrutinise in great detail. That is a very technical matter that I do not propose to go into at this time of night. For those of us who have worked in social care, we know that it is the effects of procurement law that can have the more far-reaching consequences.

The reason for having this Bill is to deal with very significant challenges to the health service, one of which is dementia. I am not going to remind noble Lords of the scale of the problem of dementia. In 30 years' time 1.5 million families will be dealing with it. It is therefore important that, throughout this Bill, carers in particular have a far greater role in the design and commissioning of services than now. I will wish to see that strengthened.

By all means, we should debate the private patient income cap. We did so in this House in November 2009, at the instigation of a noble Baroness on the Cross Benches. The NHS has raised money from private patients since approximately 1948. The issue that is more important than the cap is the requirement on trusts to show how and precisely why they have chosen to accept private patients and how it will benefit their NHS patients. It can—we know that it is possible to develop a lot of research through private income, which ultimately has a benefit for NHS patients.

I want to finish on the question of the two amendments before us. The amendment tabled by the noble Lord, Lord Rea, is clear in its motivation, its intention and its effect. I do not think the arguments for it were particularly strong and I say to those Members on the Labour Benches who have been critical of the NHS for anticipating this legislation that I do not recall PCTs hanging around in 2006 for the passage of that legislation. In 2008, the Government went ahead with appointing the chair and the chief executive of the CQC before this House had finished debating the legislation on setting up that body.

To the noble Lord, Lord Owen, I simply say that I want to defend the NHS and am as passionate about that as any of the other speakers today. This Bill deserves the most detailed scrutiny that this House can give it. The scope and detail of today's debate have shown the standard of scrutiny that it may receive. I genuinely do not see how a Select Committee of 14 people could bring the range of experience and wisdom to this Bill that I think it needs. I care about the NHS. If we have no other reason to be in this House, it is to defend the NHS. It is our duty to do that—without filibustering or playing games, but through several months of very, very hard and detailed work. My colleagues have already done much to make this Bill better. At the moment, I could not support it—there is much more work to be done. I, for one, ask for the opportunity to do my job.

10.40 pm

Lord Whitty: My Lords, I come to this from a slightly different angle. Unlike many noble Lords who have spoken, I am not an expert in the NHS. I have always had a very good experience as a patient, but I have none of the expertise that has been demonstrated here today. I do, however, have considerable experience of other regulated markets and of consumer representation in those markets, and I would like to focus on the proposals in that area in this Bill.

The Government's objective is pretty radical. They want to move the NHS from what they see as a bureaucratic state provider to a system that is run by combining internal and external market regulation. They want to see, quite rightly, some market that does not actually have a cash nexus between the provider and the ultimate consumer. I am afraid that no precedent

[LORD WHITTY]
exists for doing this in the way the Government intend. It is very important that the way in which we are moving is seen as pretty radical. This is not a marginal change; it is not straightforward continuity on some of the changes made by the Labour Government; it is not even the latest instalment on the list of the noble Lord, Lord Walton, of top-down structural reorganisations over the past 50 years.

I accept that this is not privatisation in the normal sense, but it is a change that is almost as revolutionary as privatisation was in some of the other public services. When we vote tomorrow, and later on in the various stages of this Bill if we get there, Members of this House should be under no illusion; if the Bill goes ahead, we will change the nature of the NHS and way in which it is understood by the vast majority of the public. There may be arguments for it, and we will come to that, but this is an entirely new model of delivery and a new model of regulation based on unproven premises that potentially puts in jeopardy many of the achievements of our healthcare service which, as the noble Baroness, Lady Williams, pointed out today, is reckoned by many authorities to be one of the most cost-effective in the world.

The rationale of cost saving is by no means clear. The noble Lord, Lord Cotter, recently cast aspersions on the quality of the impact assessment, with which I would not disagree, but in one regard it is commendably frank. On the potential benefits, it says on page 13 that,

"a robust figure around the cost savings or the health gains associated with the changes in commissioning is highly problematic to estimate … it is not possible to state monetised figures about the contribution that the changes in commissioning would make to this, as it is very difficult to estimate what would happen without the reforms in this instance".

In other words, there is no proven cost saving. One has to get to about page 45 to see where the real cost saving envisaged by the Government is; they identify National Health Service pensions and terms and conditions as being excessive and suggest that moving away from NHS workforce conditions to private providers will therefore provide savings. However, the commissioning proposition itself does not have an identified cost benefit.

Nevertheless, assuming that the Government get through tomorrow and that we will deal with this Bill, there are some fairly central problems about how they actually implement it. Let us take the commissioning propositions first. The ostensible reasons for changing the whole basis of procurement are twofold. They want greater clinician involvement in procurement—I do not disagree with that—and they want greater devolution of decision-making. I agree with that as well. However, greater clinician influence does not mean that the whole process is handed over to clinicians. Greater devolution should not mean huge fragmentation.

It is not yet clear to me why it was decided that GP-based commissioning was to be the preferred choice. It is not clear, from the propositions in this Bill, how we will ensure that choice in this matter—and choice is a big word in the Government's proposition—is the patient's choice and not the choice of the commissioners themselves, or of the commissioning agency or those whom they employ. It is already clear—and the poll today underlines this—that the majority of GPs do not want this move. In a few cases, GP practices and other clinicians could probably set up an administrative procurement process, but in most cases it will divert them from their central role as clinicians and in practice they will employ others—private commercial companies —to do it, and it is not clear who regulates them.

The whole process is intended to be patient-centred, but since the creation of the NHS, patients have always been confident that when dealing with their GP or any specialist they get advice based on their clinical condition and there is no contamination of that advice by the possibility of financial gain by the person who is giving it. Unfortunately these propositions raise that doubt—I put it no higher—particularly when GP practices may provide some of the services that they commission or they are associated with companies that may have some role in providing those services.

What is the exact relationship between the local commissioning CCGs and what has been termed the biggest quango of them all, the national NHS Commissioning Board, in this new system? Clearly some of the concerns that I and others have will be covered by regulations, guidelines and injunctions from that board. Are we not in danger of replacing one top-down system with another?

There was an alternative. There are bits of the Bill that I agree with, particularly the provisions on public health that bring the local authority structure and the health service structure more closely together. Why was it not possible to use those structures, where NHS structures are roughly coterminous with local authority structures, as the basis for commissioning rather than fragmenting below that level and running the risk of having suboptimal provision of procurement?

On regulation itself and the regulator Monitor, Monitor will have a range of responsibilities, some of which are contradictory. It sets prices, ensures continuity of service, provides a failure regime, licenses providers jointly with the CQC and, crucially, has the job of promoting integration while at the same time having to come down on anticompetitive behaviour. I am not sure that joint licensing with another regulator is workable. In other areas where an economic regulator does licensing or franchising, there is a clear demarcation between different regulators or, alternatively, it is all in one regulator. I cite water on the one hand and energy on the other. There are other complications because the national commissioning board would also be a quasi-regulator, and there is also the role of NICE in this operation.

Following the pause, we have a slight change in the role of Monitor in this area. It was suggested that it was a dilution in response to pressure from the Lib Dems, but a move from promoting competition, which suggests nurturing new providers, to preventing anticompetitive behaviour, which is a much more draconian potential intervention in preventing certain behaviour, is not a dilution. In the context of the health service, it is not clear what anticompetitive behaviour is because, as noble Lords have said, it is clear that collaboration, specialisation, agreement between providers—the kind of things that in general competition

law would be regarded as anticompetitive behaviour—are not relevant. In fact, not only are they not relevant; they are a huge advantage in treating many conditions and many patients in the health service.

Therefore, what do the Government mean by anticompetitive behaviour in this area? Even if, as the noble Baroness, Lady Barker, has just said, competition is primarily on quality, which I appreciate, it is still unclear what anticompetitive behaviour would be in this context. What would be regarded as cartels in other markets are clearly collaboration, collusion and the delivery of integrated services in the health service. Even more fundamentally, competition and choice require surplus. Is the price-fixing that Monitor will be required to engage in fixing a price at a level that ensures surplus? If so, what is the cost-effectiveness and value for money of that?

My final point relates to consumer representation. HealthWatch is a good new concept. However, consumer representation has to be independent not only of the provider and the Government but of the regulator as well. The location of HealthWatch in the CCG is not independence. It is not clear that it will have its own resources or staffing, and it is regarded in the proposed legislation as a sub-committee of the regulator. That is not appropriate, independent consumer representation for the patients of the NHS.

The Government are in a bit of difficulty on this Bill. They may be in difficulty tomorrow, and they will certainly be in difficulty as we go into Committee. However, I hope that in considering the Bill, some of the central issues relating to the nature of the regulation and consumer involvement in the health service will be addressed when some of the questions that I and others have raised are answered.

10.50 pm

Baroness Meacher: My Lords, I shall address only three issues—I am sorry; I am losing my voice. The starting point for any reform has to be to define the problem. The Government have defined excessive bureaucracy as the key. Having, in my view, identified the wrong problem, it is not surprising that the Bill comes up with what I would regard as the wrong solution—wholesale organisational change. The real reasons for the financial pressures on the NHS are twofold in my view: first, the failure of the system under all political parties over the decades to lead to the necessary closure of hospitals in the interests of patients; and, secondly, the failure of commissioners over the years to identify the need for much smaller acute hospitals—a wholesale shift from acute hospital beds to community services.

Will the new structures make it more likely that the essential closures will occur in the future in contrast with the past? The King's Fund is concerned that there should not be too much centralisation of power. I am sure that that is right for many decisions but, in the case of service closures, surely only the NHS Commissioning Board will have the clout and the independence from local campaigning groups to judge the evidence objectively and to make unpopular decisions, when necessary. Of course, local campaigns are legitimate and important but difficult decisions are quite another matter. The Minister puts his confidence in local authorities, health bodies and consultative groups to undertake a needs analysis and take responsibility for closures. My heart sinks.

The noble Baroness, Lady Williams, has strongly supported the continuation of the Secretary of State's powers. With respect to most decisions I support the noble Baroness wholeheartedly. However, when closures or reconfigurations have to be made in the interests of patients and the long-term health of the NHS, then in my view if the case has been made out—the evidence is there—and is supported by the NHS Commissioning Board, the Secretary of State should only need to satisfy himself or herself that the proper procedures have been followed. At this stage, I have no confidence at all that the new system will be any better than the old in this all-important respect unless we manage to make a key amendment during the passage of the Bill. I know that there is some discussion and thought about the precise role of the Secretary of State. I think that we have to have evidence-based decision-making, and it is very difficult for politicians, whatever their colour.

I now want to turn to the need for the wholesale closure of acute beds and investment in intensive community services for patients with long-term conditions, terminally ill people and those with dementia. We know that hospitals are the worst possible place for these patients, yet vast numbers enter hospital for a procedure that requires perhaps only four, five or six days in hospital but they never get out. Why? It is because there are no intensive community care services to enable them to do so. What will the Bill contribute to this problem? In my view, nothing.

The transformation happened in mental health about 30 years ago, with the wholesale closure of big asylums and their replacement with small in-patient units and a complex array of community care services. There was shock and panic at the time but it was the right policy. Now, with modern surgical techniques, day surgery and very short hospital stays, the time is right for a similar revolution in acute medicine. Indeed, I remember the noble Baroness, Lady Bottomley, saying exactly that when she was Secretary of State all those years ago. It has not happened.

Today, then, elderly, terminally ill people and those with long-term conditions remain in hospital, deteriorating, becoming more demented, underfed and even starved of water on occasions. Soon, discharge from hospital becomes impossible. The average length of stay of these particular groups before they finally die a miserable death in a hospital bed is about two years. All this could be resolved with good commissioning and leadership from the top.

In East London, our commissioners—no credit to me at all—took this step, de-commissioning just one ward and investing in intensive community care. We call it a virtual ward. The savings are £2 million a year; the ward costs £3 million a year to run; the community costs are under £1 million; and 623 patients have been through the virtual ward in just six months, with an average stay in the virtual ward of 10 to 15 days before returning to normal community care. Early feedback suggests that patients are very happy. No legislation was required to do that and it needs to be replicated across the country, as it can be.

[Baroness Meacher]

My third point concerns the threat of privatisation of NHS services and even hospitals. The Minister assured me yesterday that the capital assets of a hospital would not be sold to private profit-making companies. This is of immense importance. Once a hospital is sold it will be almost impossible to get it back into public ownership. The irreversibility of some of these developments is one of my big concerns about the Bill.

We know that the profit motive is entirely unsuited to the health service. The *Economist* calculated that the market-driven US healthcare system in 2009 generated between $250 and $325 billion of charges for unnecessary care. The UK cannot afford such waste. Also, what of the patients put through unpleasant procedures to provide profits for others but no gain and perhaps risk to themselves? That is why I feel so passionately about this issue.

I agree that competition is healthy but can the Minister give an assurance on the Floor of the House that profit-making organisations will not be permitted, as he said yesterday, to take over the capital assets of hospitals. This at least would enable future Governments to reverse the planned privatisation of services. I hope that the Minister may even go further. Trusts and other not-for-profit organisations can provide healthy competition. Can the Minister give the House some assurance that such organisations would be regarded as preferred providers when compared with profit-making companies, bearing in mind the experience in the US, Germany and elsewhere?

This is an unnecessary, costly and—I hate to say—potentially dangerous piece of legislation. I hope that the Minister can allay some of my fears tomorrow.

10.57 pm

Viscount Bridgeman: My Lords, I declare an interest as a former chairman of the Hospital of St John and St Elizabeth, in St John's Wood. That hospital is unusual in that it is an independent hospital that has within its charity, and on the same premises, St John's Hospice which is wholly National Health Service, contracted to seven primary care trusts north of the Thames. Anyone who works in that environment has the experience of the excellent relations between the private and the public sectors. We receive considerable help and have very good relationships with the adjacent teaching hospitals of St. Mary's Hospital, the Royal Free Hospital and UCH. Fortunately, the conflict between private and public sectors is no longer a burning issue and it certainly does not form a major part of the current Bill, so in the short time available, I intend to speak to other aspects.

The Minister has articulated, with admirable clarity, the basic reasons why major reform of the National Health Service is now needed. He rightly went back to the origins in 1946. The understandable expectation of Ministers at that time was that the health of the nation would be brought up to an acceptable level and that in these broad, sunlit uplands, the role of the National Health Service would be one essentially of care and maintenance.

However, as my noble friend has said, there have been three developments, which were understandably, in the uncertain times just after the war, not then fully appreciated: namely, the rising expectation of patients, the fact that life expectancy has now increased so markedly—a tribute to the huge success of the NHS—and last, but unfortunately not least, the massive progress of new technology and its exponentially rising costs. We have been given a homely example by my noble friend Lord Eccles, who is not in his place, of the progress in the dental drill. Add to this the present economic situation and it is clear, for that reason alone, that doing nothing is not an option, a sentiment echoed by several noble Lords from all sides of the House.

In his impressive speech, my noble friend also paid tribute to the origins of the reforms initiated by the previous Administration, although the noble Baroness, Lady Thornton, appeared slightly reluctant to accept quite as much of the credit as my noble friend was offering.

At this late hour, I want to touch on only one aspect of the Bill's proposals: the creation of the CCGs. A point made by a GP for whom I have a very high regard is that there are more bad GPs and more bad GP practices than is generally supposed. Some GPs are on their own out of choice; others are on their own because they cannot get on with their partners in the practice—which in itself begs a question. So often, these sole or very small practices are underresourced both in personnel and funding. This is where the CCGs will be in a position to provide the resources which enable the weaker-performing practices in a group to be brought up to an acceptable standard. I remind your Lordships that it will be obligatory under the Bill for every general practice in England to join a CCG.

The PCTs, which the CCGs will replace, have been far too small in many cases and have spent far too much time competing with each other. The CCGs will be larger and better resourced. Not only will they be charged with commissioning services not provided directly by GPs but they will also have access to clinical networks advising on single areas of care such as cancer—that possibly addresses a point raised by the noble Lord, Lord MacKenzie, who, too, is not in place; perhaps my noble friend the Minister can confirm it—and to the new clinical senates in each area of the country which will provide multiprofessional advice on local commissioning plans. There is also HealthWatch, a powerful new watchdog set up to fight for patients' rights and referred to by the noble Lord, Lord Whitty. I also welcome the inclusion of a nurse—usually, I imagine, from a practice—and a consultant specialist on CCG boards, a recommendation of the independent review forum. All these bodies will be hosted by the NHS Commissioning Board.

I have listed these groups in some detail because I suggest to your Lordships that, with all these interlocking bodies, the possibility of cherry picking or of cosy deals where there is a potential conflict of interest will hopefully be eliminated when it comes to commissioning, for this has been a concern running through so much of the correspondence that many of us will have received.

I am sure that I speak for many when I say how I have once again been reminded in this huge amount of correspondence just how much the NHS is loved and respected, and just how much gratitude it inspires. It is

only natural for many people who owe it so much to feel that any substantial change must be for the worse. The public as a whole are unaware of how much the service must change. I hope that my noble friend the Minister, who has done such an admirable job in setting out his stall today, will with some urgency address the need to communicate continuously with the public to get over the message of what the Bill sets out to achieve. And achieve I am sure it will in marking a seminal stage in the further development and improvement of what has been referred to more than once today as our greatest national treasure.

Perhaps I may refer to the amendment proposed by the noble Lord, Lord Owen. Today's debate has once again seen your Lordships' House at its best. It has been conducted conscientiously, courteously and constructively, which I am confident will be carried through to Committee. I hope that those noble Lords who are uncertain as to whether they should support the amendment of the noble Lord, Lord Owen, will feel reassured that the Bill will receive proper scrutiny—which includes addressing the constitutional issues—wholly on the Floor of this House and will therefore not support his amendment. I myself will not be supporting it.

11.04 pm

Baroness Smith of Basildon: My Lords, clearly, in a debate of this length, there will be some repetition on various issues. There is an old saying "everything has been said but not yet by everyone". But having listened to most of the speeches in the Chamber or on the monitors today, I know that is not true of this debate. The length and complexity of the Bill makes it a little like an onion—every time you peel another layer, new issues and potential consequences become evident, as we have heard from so many of the expert contributions today. I do not want to raise issues that have been raised already, but what has struck me during this debate is that many noble Lords who are not supporting either of the amendments before us today have still referred to their serious concerns about the Bill and said that your Lordships' House should seek to make significant amendments in Committee. That should warn the Government how deep the concerns are about the Bill.

I can think of few Bills that have caused so much controversy and concern in Parliament and in the country as a whole. I was told before I came back into the Chamber this evening that in just 36 hours, 100,000 people have signed a petition collected by 38 Degrees in support of the amendment of the noble Lords, Lord Owen and Lord Hennessy. That is a hugely significant number.

I am not an expert but I listen to the experts and even after the Government had their extraordinary pause after the Committee stage in the other House and made amendments, they failed to satisfy or give confidence to the very people who have responsibility for implementing the Government's changes. Today, the Royal College of General Practitioners in a poll of around 1,900 of its members announced that only 4 per cent agreed with the reforms and 70 per cent said that they were against the Government's reforms as they stand at present in the Bill. More alarming for the Government, nearly 30 per cent were more opposed to the Bill after the reforms than they were before.

The Royal College of Nursing said that the Bill would have a serious and detrimental impact. The BMA has called on Peers to reject or substantially amend the Bill and 400 public health workers wrote to all Peers last week opposing the Bill as it stands. Some 60 medical professionals, including hospital consultants and the General Secretary of the Royal College of Midwives, say that it needs suspension or significant amendment. The noble Baroness, Lady Hollins, as a past president of the Royal College of Psychiatrists, spoke earlier about its serious concerns.

This is extraordinary. Those speaking about the Bill are professionals—people whom we trust with our care. They have no reason to oppose the Bill other than their professionalism. If the Government cannot give confidence to the professionals, how can we then expect the professionals to give confidence to the public?

I have two main areas of concern. The first is the level and degree of change. This is a huge structural change for which there is no mandate. Also, any change of this significance has to be evidence-based. I have not seen the evidence that tells me that we need legislation to effect this degree of structural change in order to move towards more clinical involvement in commissioning. Even the Secretary of State, Andrew Lansley, said that 90 per cent of the Bill could be achieved without the legislation making such substantial structural change. If we see this also against the backdrop of financial pressures in the health service, stresses in the system and increased waiting times, that adds to the complexity of having to drive and push through change at a difficult time. With such significant change, there has to be support and confidence from those who are expected to implement the new system. There is evidence that the Government do not have that. I have no doubt that even if the Bill becomes law—and I hope we will see significant changes—staff at all levels in the NHS will do their best to make it work. But that is too much for us to ask of them and I do not believe that that is how this House wants to proceed.

My main medical concern is the fragmentation of the system, which will make collaboration and integration of services—between health and social care in particular—more difficult. If your Lordships' House is concerned about a postcode lottery now, imagine how it will be when all GP practices are responsible for commissioning. We have seen the pressures the health service is under. Your Lordships may have read reports of the letter from the Haxby and Wigginton Health Centre in York last week. Having set up its own company, HBG Ltd, to undertake minor private operations, it has now written to patients waiting for such minor surgical procedures with a price list, given that these procedures are no longer available on the NHS. You can have a skin tag removed for £56.30, a sebaceous cyst removed for £214.01 or a benign lesion, including a mole, removed for £243.

Unfortunately, it does not take too much imagination to imagine the impact that that could have on patients if replicated across the country, especially in times of

[Baroness Smith of Basildon]
financial constraint. How many other GPs will set up their own minor surgical units to undertake private work or seek out partnerships with private providers?

With all those changes, the Bill is also a genuinely missed opportunity to tackle some of the most difficult and entrenched problems in the health service. With such substantial legislation, we need to ask: what are the greatest problems facing the National Health Service; and does the Bill address them in a way that adequately deals with the problems?

To take one example, most experts are agreed that the spiralling costs of providing quality and appropriate health and social care for an ageing population is one of the greatest challenges. So many older people are admitted to acute care. Whatever the ultimate reason, it is often as a result of inadequate integration between health and social care which could have improved their quality of life and helped them to stay safely in their own homes for longer. That challenge must be met. It is a structural problem, a health problem and a cost problem.

Imagine an 82 year-old, Mrs Brown, who is quite frail but otherwise fairly healthy. She just needs a little extra care, support and attention in her own home. She may have a minor medical problem. It does not require hospitalisation, but it cannot be met by social care alone: it is a medical need. Currently, her medical care is free, and her social care will usually be charged, but it is basic social care in her own home that is most likely to keep her out of an acute hospital. For Mrs Brown's quality of life and to reduce the pressure on acute care in the health service, we all know that it would be so much better to provide for all her needs at home as long as possible.

Despite the best intentions behind the Bill, with the health and well-being boards, the way that it fragments services will make that even harder to deliver, as the noble Baroness, Lady Wheeler, outlined earlier.

A well kept secret, although not among my friends and family, is that I am not a great fan of the *Guardian* newspaper, especially after it recommended to its readers that they vote Liberal Democrat at the previous election—but every sinner has an opportunity to repent. I commend to your Lordships tomorrow's *Guardian* editorial. It advises Labour and Cross-Bench Peers to vote against Second Reading but then advises all Members to vote for the Motion proposed by the noble Lords, Lord Owen and Lord Hennessy. I will not indulge your Lordships' House by reading the entire editorial, although I recommend it, but it states, as a message to Liberal Democrats:

"The descendants of a liberal party which helped to found the NHS now must decide whether they are prepared to risk a row to defend it. Capitulation here could carry a higher price than raising student fees".

I regard that as essential reading for all Liberal Democrats in your Lordships' House and another place.

On the evidence so far, I have grave doubts about the Government's willingness to accept changes that may be brought forward by your Lordships' House by effective scrutiny. For that reason, I feel that I have to vote for the amendment of the noble Lord, Lord Rea, but I shall also vote enthusiastically for the amendment of the noble Lords, Lord Owen and Lord Hennessy, because I have no doubt that the only way that this Bill can be made fit for purpose, or be improved to serve the best interests of the population of this country and the NHS, is by effective, detailed scrutiny. It will be hard work, but the penalty to pay if we do not undertake that scrutiny is that we lose the NHS, which we value so much.

11.14 pm

Lord Adebowale: My Lords, I shall speak briefly at this late hour but first I declare some interests. I am the chief executive of Turning Point, a social enterprise that provides health and social care services to probably over 140,000 people in 250 locations. I am a member of the National Quality Board and the NHS Future Forum, about which I will speak in a minute. I also took part in the Commission on 2020 Public Services review and am an honorary president of the Community Practitioners and Health Visitors Association. Just in case noble Lords are wondering whether I get any sleep, I am also a non-executive director of a small IT company that provides services to the NHS. The most important thing for me, though, is that my mother was a nurse in the NHS for 30 years, and that the NHS actually saved my life. The NHS runs in my bloodstream—literally.

I shall make some remarks about my experience of being part of the listening exercise and on the Future Forum. I have been listening hard, so hard that my ears still ring, not just to the experts such as the RCGP, the BMA and the RCN, whose leaders I have taken the trouble to trouble about their opinions of the Bill, which have often been convoluted or misrepresented in some of the press—the best way is to talk to them directly—but also to ordinary people, my neighbours, GPs and people who have sent me e-mails by the hundred about the Bill.

While I have every admiration for Professor Field and his herding of the cats that were the members of the forum, I have greater admiration for the Minister in his attempt to persuade the BMA, the RGCP and the RCN that the Bill is a good thing. I can speak only from what I hear, and the leaders of those organisations are not in favour of the Bill; that is what they have told me face to face. As has been said, one has to respect the voice of such well respected and experienced professionals. I have heard that the leaders of these organisations may not represent their membership in their expressions of concern about the Bill. I do not agree; certainly, from the number of e-mails that I have received, I think we have a problem, which cannot simply be put to one side by saying that people's fears are imagined.

However, having said that, I have said publicly that the Future Forum exercise was flawed. It is always a good idea to listen, but it is better to listen at the start of the process rather than at the end. Still, it is better to listen than not to listen at all, which is why I took part. Indeed, some changes have been made to the Bill that I welcome, as have many Peers. The strengthening of the health and well-being boards, the greater emphasis on the JSNA, the rhetoric in the Bill about integration and the role of Monitor are all welcome, but they are not enough in themselves. I shall explain why.

There are issues around Monitor and related issues around competition, such as the definition of competition, what Monitor does and how it does it. Frankly, competition has been rife in the NHS for as long as I can remember; it is part of what the NHS is and does. That is not really the issue; the issue is who benefits from that competition and how it is managed. Not enough has been said about the need for collaboration. Anyone who knows anything about systems in which there are limited resources knows that competition can actually waste resources. What you need to do—rather boringly, some people think—is emphasise collaboration. That is what is necessary, particularly with regard to organisations like mine, which is a not for profit company competing with the public and private sectors.

I note the point made by the noble Baroness, Lady Barker, about quality. I agree that one could argue that the elements in the Bill that reflect the Government's intent to emphasise quality, not just cost, are welcome. As is always the case, though, quality is hard to define when cost is the imperative and budgets are tight. The Bill does not say much about the balance of judgment between quality and cost in these decisions, so I am still concerned about that. I will be getting up at 6 o'clock tomorrow morning to explain to a load of social enterprises why and how to survive in the world of competition described in part of the Bill.

Let me rush to some kind of conclusion. My major concern is whether the Bill will reduce health inequalities. This is something that was not mentioned in the Minister's introduction, yet it is central to the Bill. Inequality is not just immoral but very expensive. The core purpose of any change to the NHS must be to reduce health inequalities, yet it is not mentioned. It was mentioned by the noble Baroness, Lady Armstrong, and others. As the co-chair of the APPG on complex needs and chief executive of an organisation that focuses on complex needs, I want to tell the House that it is not a question of the things that have a tariff, the things that have a market or the things that happen in hospitals. It is the things that do not have a tariff, the things that do not happen in hospitals and the things that we do not discuss that dictate the future. We do not discuss complex needs and they will dictate the future and the cost to the NHS. They need to be discussed.

We have not discussed the inverse care law. If the Bill does not show how it will reverse the inverse care law, it will fail—and fail in several ways, not just in relation to cost.

We talk about commissioning but I rarely see commissioning. Even in the course of this debate people have used the term in several different ways. The noble Lord, Lord Whitty, referred to procurement. I think he meant commissioning. Others talked about purchasing. I have a problem in that commissioning is hardly defined, yet we know that commissioning defined is services delivered. I should like the Bill to say much more about what commissioning is, what is expected of commissioners and how they will be held accountable. It is certainly not good enough that the clinical commissioning groups will have to pay due regard. There has to be a plague on the houses of both health and well-being boards and clinical commissioning groups so that they deliver a joined-up vision of services in an area—one that respects a definition of commissioning as the means by which you understand the needs of an individual and/or a community such that you can build a platform for procurement. Note that it is not the same thing as procurement.

Such a definition might go some way towards driving what the Minister referred to when he mentioned HealthWatch and ensuring that communities have a say in what gets commissioned on their behalf. I am very concerned that we are loading a lot on to HealthWatch at a time when we are reducing its resources and, indeed, making the mistake of making those resources susceptible to the very people whom HealthWatch will be criticising. This was pointed out by the noble Lord, Lord Harris.

I end by asking the Minister to respond specifically to the following points in his summary, as well as the points that have already been made by me and other Peers. First, there is the overall responsibility of the Secretary of State for universal healthcare. Forgive me; I am an unsophisticated politician but it seems to me that the NHS is a political construct. Many people who have spoken to me do not really care whether the Secretary of State says that he is responsible or not; he will be. We have a duty to ensure that that responsibility is made clear. Who is in charge? It will be the Secretary of State. Secondly, there should be a responsibility on community commissioning groups not just to pay due regard. We should ensure that there is a duty on them to show how they have engaged the JSNA and the health and well-being board in their commissioning decisions. Thirdly, commissioning should be defined and structured in such a way as to ensure community engagement. That is the only way that you will engage people at the sharp end of the inverse care law. Finally, commissioning should be held to account for the quality of its engagement with health and social care in the community in any given area. I look forward to the Minister's response and to further debate in Committee. I have not decided what to do about amendments but that is, frankly, the least of our worries.

11.24 pm

Lord Morris of Handsworth: My Lords, like many in this debate I am also a long-term user of the National Health Service, as are my family and friends. As I move towards my advancing years, I recognise that I am likely to become more dependent on the NHS, as are my family members. We have much to be thankful for in its dedicated service and the people who provide that service. It is accepted that our publicly owned, publicly funded and publicly accounted National Health Service is admired throughout the world. It is universal and comprehensive and of course free at the point of use. It is dedicated to making a difference, not a profit. It is designed to ensure freedom from fear for every man, woman and child in our country, regardless of gender, race, religion, sexuality, class or income. I believe in the NHS. I value what it does. We all do.

Actually, I thought David Cameron did too. I recall his words at the Tory party conference in 2006. They are worth repeating. Back then, David Cameron declared proudly:

"Tony Blair explained his priorities in three words: education, education, education. I can do mine in three letters: NHS".

[Lord Morris of Handsworth]
He also said:

"For me, it is not a question of saying the NHS is safe in my hands. Of course it will be".

He went on to promise no more pointless, disruptive reorganisation. He promised that change would be driven by the wishes and needs of the NHS professionals and patients. Well, Prime Minister, far from ending pointless disruption, this Bill as it stands will bring about the biggest and most costly and pointless reorganisation in the entire history of the NHS. As far as I understand it from all the professionals and patients, this Bill's changes are being driven and forced through against the advice of and without the support of virtually every professional health body and patient group in the country.

Based on that 2006 conference speech, the Prime Minister would be voting against the Bill that he is pushing through in 2011. Not only is this Bill a cocktail of untested proposals which are considered reforms, but they are proposals without any electoral mandate. As we have heard time and again today in this debate, neither the Conservative nor Liberal Democrat manifestos contained these proposals. There was no mention of them in the coalition agreement. This Bill and its radical proposals have come entirely out of the blue—in every sense, judging by the political philosophy that seems to underpin them.

I said that the NHS was designed to ensure freedom from fear, but fear has dominated much of what has been said in this debate. We have been inundated with letters and e-mails condemning these proposals. Ordinary men and women are expressing their fears and concerns about the future for themselves and their families, as publicly as they have the means to do so. We fear most that the NHS could be dismantled through lack of any real co-ordination, any real commitment and the consultation that never really happened. No one in our country voted for this Bill and I trust that not many in your Lordships' House will do so either.

11.30 pm

Lord Crisp: My Lords, there is a great deal that is good in the Bill, but I am going to speak only about the areas that I think are problematic. I was chief executive of the NHS and Permanent Secretary at the Department of Health for five years, and I know as well as everyone else in your Lordships' Chamber that the NHS has improved but that it needs continued and continuing improvement. Every Friday for more than five years I went out and about visiting hospitals and surgeries, and saw the good and the bad. The good was wonderful. There was more of that but there were also some bad and shocking things.

My biggest impression is that the Bill is a wasted opportunity—I follow the noble Baroness, Lady Smith, in this. In part, that is because despite all this upheaval the Bill does not focus on the major issues that the NHS is facing; in part, it is because of the poor process; and in part, it is because the Bill does some unnecessary things. On the process, I entirely exempt the noble Earl, Lord Howe, and, like others, I congratulate him on the way that he has brought so many people to meet us in your Lordships' House and explain and discuss the detail.

However, there is also the big issue of trust that the noble Baroness, Lady Williams, and the noble Lord, Lord Owen, have raised and which the Government must address. The underlying issue here is that the NHS is a social contract with the country's citizens. I suspect that people, whatever their politics, fear that changes will be made in that implicit social contract and that—the NHS constitution notwithstanding—we will move towards a set of commercial contracts that treat us not as citizens but as customers. We have expectations that the Government will secure our health and healthcare, and that doctors and nurses in the NHS will always do their best for us. That goes much further than the small print of contracts. I echo the point made by my noble friend Lord Adebowale that the things that are not in the tariff are as important for many patients as the things that will be in the tariff and the contracts. This is therefore about solidarity and trust, and people see this as being put at risk—rightly or wrongly—both in the role of the Secretary of State and in some of the aspects of competition. I shall come back to that.

The Bill is a wasted opportunity because there are two basic problems with it and with the process that got us here. The only unifying themes in the Bill are structural; they are not about services or the issues that the NHS has to face up to about securing cost or securing improved quality. A number of noble Lords have also spoken about how the largest number of patients and the greatest cost for the NHS are people with long-term conditions—often multiple long-term conditions—who need a different sort of health service from the one we have. We are still too hospital and doctor-focused. We need to be more community-focused and much more people-focused. That is about major service change.

Belatedly, issues of integration have been brought into the Bill, but if they were really at the heart of the legislation the Bill would be about providing health and social care in a much more integrated way and we would be clear about how strategic change will happen. It is not at all clear that local groups can do this and, frankly, the levers of markets and GPs being in charge are not enough to achieve the changes we need. This is compounded by the problems of changes and the compromises that have been made so far in the passage of the Bill, which will add bureaucracy and inertia. We are retrofitting changes to an already complex and untested Bill. All this is made worse by a failure to communicate.

I move on to specific points. On the issue of the Secretary of State, as a former chief executive and Permanent Secretary, I recognise the importance of separation between the various roles. The noble Baroness, Lady Bottomley, talked about her perception of that. Perhaps I may say that as a former chief executive, being rung at this time of night, and indeed an hour later, pretty regularly by more than one Secretary of State, I should quite like there to be that separation for my successors. I know that people will say that the words that have been changed only confirm what has happened and that it will be okay when the failure regime is in place—and that therefore there will be a mechanism for dealing with failing trusts—but frankly this is risky; this is untried regulation.

We only need to think of the banks—we did not get the regulation right there. This is also an issue of trust and expectation, and it is unnecessary if we understand what the Constitution Committee said. If the Government are prepared to be at all flexible, we can get this right relatively easily. There is no huge set of issues that need to change. I also ask the question asked by the noble Lord, Lord Williamson: why was it necessary to make that change?

I am very much in favour of local decision-making, and, as a number of noble Lords have said, over the years we have seen more devolution to primary care groups, to primary care trusts and to many others. These have been successful in some cases and not in others. GPs in the lead and clinical roles are obviously fundamental, but there are risks here, which have not been talked about very much yet, of conflicts of interest and damage to the reputation of doctors. I know that the noble Baroness, Lady Royall, mentioned one particular case where it is already being suggested that doctors are acting in their own interest.

Let me be clear; I am not being critical of GPs in saying this, and I recognise that some people believe that the code of medical ethics will mean that doctors will always put patients first. However, we only have to look at other countries to know of many examples where that has not happened, and while it may happen this year the question may be whether it will happen in 10 or 15 years' time. This could damage the reputation of doctors, and it does not have to happen. This is about perception, reality and trust. That is what needs to be tackled, and we need better arrangements for handling this. Again, I believe we can find them during the scrutiny process, but the Government need to address this and make it clear.

The noble Lord, Lord Darzi, talked about what in his experience worked best with a coalition of patients, clinicians and managers—not just GPs. I do not see this yet in the Bill. There is not enough focus on patient power, for all the reasons that the noble Baroness, Lady Masham, raised. It is not only doctors who understand health; patients do, albeit in a different way, but they need the space and greater power and influence, not as consumers but as citizens and participants in their own care. If the Government were being really radical, they would have given them more say in this Bill.

I could also go on about social services, and while I welcome the public health and other provisions there needs to be more scope for sharing budgets and for aligning action between the NHS, local government and other local actors. One result of these sorts of concerns is that the Bill has added bureaucracy and complexity. Starting without a clear service focus and integration is leading to even greater complication.

Let me touch on competition. In my experience in the NHS, the introduction of competition clearly worked, providing patients with choice and introducing ISTCs. I can show noble Lords the graphs that showed the results change, often because of the threat of competition. We saw competition as one of the other tools the Government have to make change happen.

Something that has not been mentioned very much is that new entrants are fantastically important. This week I have seen people from mental health services who have some really good ideas about changing mental health services. We need to get new entrants in, and to encourage new entrants from the voluntary sector and other areas and not just the private sector. Something else I have not heard said is that just as the public sector is diverse, so is the private sector. Some people are very much driven by the same passion that you see in the NHS, and we should not forget that.

Nevertheless, there are outstanding questions about competition. Will competition law stop mergers? Can the Minister tell us what the limits of markets are? My noble friend Lord Adebowale made a real point about collaboration. Competition can be a tool, but it is really not the only one.

I have other concerns about the commissioning of primary care, patient confidentiality, some aspects of professional regulation and education and much more—but let me be pragmatic. I know from my experience how difficult it is to make change, and how much foundation trusts and choice were opposed. I also know that the NHS wants clarity, and we must give it to it. As always, my former colleagues will get the best deal for patients within whatever political framework they are given. That is what they do. We have the chance to improve the framework. The Bill can be improved, but we need enough time to do so. Perhaps most importantly we need to make sure we maintain the trust and faith of the public, maintain the improvement and maintain the NHS as a social contract and not a commercial one.

11.39 pm

Baroness Whitaker: My Lords, it is always a pleasure to follow the noble Lord, Lord Crisp, after his broad sweep. I want to focus on two much narrower areas, which do not seem well served by this Bill. The first is mental health, and I declare an interest as a former member of the Tavistock and Portman NHS Trust. It is fair to say that mental health has always been underfunded, considering its importance to our general health, so eloquently described by the noble Baroness, Lady Hollins, and its importance to our well-being and the economy. Old people in particular seem to be rather left out of the reckoning. I believe that the National Service Framework for Mental Health applies only to people below 65. This is odd when you think where dementia strikes most.

Professor Lewis Wolpert, in his illuminating book, *You're Looking Very Well*, says that fewer than 10 per cent of older people with clinical depression are referred to specialist mental health services. Some 40 per cent of those in care homes have been reported to be depressed. Indeed, more than 2 million older people over 65 have symptoms of depression; but according to Age Concern the vast majority are denied help. Would independent provision of these unpopular specialisms have any traction on this huge lack of capacity? How can this Bill prevent such ageism?

I am also aware of long waits for basic assessment; even when people have attempted suicide, three months is not uncommon. Waiting lists for this significant area of health are not being kept low, as David Cameron promised. How does the Bill improve this dangerous delay?

[Baroness Whitaker]

To focus down to the Tavistock's own part of London, wholesale reorganisation of treatment capacity, perhaps more properly called elimination, is already having an adverse effect on patient care; some in-patients have been transferred far away from their families, while some small and valued local centres, like the Camden Psychotherapy Unit, have fallen foul of changes in council tendering criteria and suddenly have no funding. The CPU treats 90 patients a year, many of them vulnerable and socially deprived. They will lose their local service. These are not people who can always easily travel, and clinical excellence has lost out to larger, apparently more commercially attractive providers. I think that the Bill allows centres to close without public consultation, so will this problem become more widespread? What assurances have we that there will be the wish or the capacity to commission mental health services to the extent necessary?

The second area of concern to me is speech therapy, another field of supreme importance to our ability to go about our lives. I speak as a patron of the British Stammering Association and, indeed, as a long-term practitioner of stammering. But there are, of course, very much more severe communication problems than stammering, as a consequence of stroke, cancer, brain injury, learning difficulties and hearing impairment, which effectively impede relationships, proper education and employability.

I am grateful to the Communication Trust for the following disturbing figures. My noble friend Lady Wilkins had some more. Over 1 million children have speech, language or communication needs not caused by external factors such as language neglect or having English as an additional language—that is two or three in the average class. Over a quarter of all statemented children at primary level have specific language impairment needs as their primary need. It is the most common disability in childhood. Communication difficulties are common in young offenders, looked-after children and those who have conduct disorders and other behavioural difficulties. Alleviating the communication problems has a dramatic effect. The noble Lord, Lord Ramsbotham, referred to this. It really matters to intervene early if these children are to be given anything like a fair chance in life. GPs do not tend to refer early enough in the case of stammering, which is a very intractable disability, and they do not always know enough to realise what needs to be done. Only 9 per cent of childhood referrals come from GPs. Other health workers tend to refer earlier, and more effectively. Commissioning is at present complex and fragmented, so there is a very good case for speech, language and communication needs to come within public health. Can the Minister tell me whether this is the case? Does he recognise the importance of integrated commissioning for speech, language and communication services, not just within the health sector, but also between health and education commissioners, to which my noble friend Lady Wilkins also drew attention?

There are risks in the proposal to split responsibility for the commissioning of children's public health services, with the NHS Commissioning Board responsible from the mother's pregnancy to five years, and local authorities for five to 19 year-olds. So what role will the health and well-being boards play in ensuring effective and co-ordinated commissioning of children's services, and can the Minister confirm whether the boards will be encouraged to consider pooled budgets and joint commissioning arrangements for speech therapy services for children?

11.46 pm

The Earl of Clancarty: My Lords, I rise, as others are doing, who do not usually speak in a health debate, to register my own concern about this Bill, with its potential far-reaching significance. If I have interests to declare, it is that my wife is a health journalist and my brother a surgeon who, like many, is devoted to the NHS as a public service.

Despite its faults, since its inception the NHS has been over decades a public service without equal. In my case, as someone with a chronic condition—asthma—I have benefited from the way it has been managed, indeed the way that the NHS still is able to handle long-term conditions. But I have also seen the NHS at its best in acute situations, such as when my own daughter was born nearly two months premature. Undoubtedly, her life was saved by the NHS.

The question I would then ask is: would these have been managed as well, and for free, under private care? I do not believe that they would, but more authoritative support for that belief lies in the huge number of briefings that we in this Chamber have all received from the healthcare experts themselves: from doctors, consultants, nurses, patients, academics, institutions, organisations, hundreds of people—indeed the tip of an iceberg of opinion, the overwhelming majority of whom are highly critical of this Bill, and critical in much the same vein, which is that the move towards greater commercialisation, a road that this Government are already proceeding down before this Bill is even passed, will be a huge disaster for the NHS.

This is an important question, because the main threat to the NHS lies in the introduction of the free competitive market, and indeed the noble Baroness, Lady Jay, has already given us today the example of Assura Medical being the preferred bidder for Surrey community health services over an award-winning social enterprise.

I believe that if an entity such as the NHS changes radically its internal workings, then the message and meaning of that entity must also change. This is why I share the fear many have that the NHS will simply become a kitemark, because what was previously the key aspect of that entity—healthcare that was universal, comprehensive and free—will simply not be compatible with the NHS's new construction.

In the first instance, though, and what should be greatly disturbing to the public, is the discrepancy between on the one hand what the experts think and say, and on the other what the Government say they are doing and what they say the experts feel about this Bill.

If the term "privatisation of the NHS" had been used by any party in its manifesto, we all know that no voter would have gone near it. Andrew Lansley denied last week at the Conservative Party annual conference that that is what the Government are doing when he said,

"the NHS will never be fragmented, privatised or undermined".

Yet in the—perhaps to his credit—more transparent words of the Minister at the Independent Healthcare Forum on 7 September, previously mentioned in this debate by the noble Lord, Lord Clinton-Davis, not only did he say that there will be,

"huge opportunities for high quality companies"—

but that—

"we want to create as level a playing field as possible".

To me, that is as clear a signal of an intent to privatise the NHS as one could possibly give, whether such intent is acknowledged or not. It does not take a healthcare expert to understand, even with checks in place, but with a marked reduction in accountability for the Government, as this Bill would effect, that our National Health Service would become an industry where the public NHS is only one provider among a host of private ones; and one that may very likely eventually be squeezed out altogether.

This sense is supported by what the healthcare experts say. Organisations including the Royal College of General Practitioners, the BMA, the Royal College of Nursing, the Royal College of Midwives and many others directly contradicted David Cameron's statement on 7 September at Commons Question Time of healthcare organisations' support for the reforms.

The problem in recent weeks is that the Government have had the louder voice—what Andrew Lansley and David Cameron say gets coverage in the media. The healthcare experts, by and large, have not had that coverage. However, it is right that we should give a voice in this Chamber to these views. They are not being given enough of one, and, to be blunt, I know as a non-healthcare expert, whose views I would rather pay attention to.

For example, there can be no more damning indictment of this Bill than the letter published in the *Daily Telegraph* on 4 October from over 400 top healthcare professionals that stated:

"The Bill … ushers in a … degree of marketisation and commercialisation that will fragment patient care; aggravate risks to individual patient safety; erode medical ethics and trust within the health system; widen health inequalities; waste much money on attempts to regulate and manage competition; and undermine the ability of the health system to respond effectively and efficiently to communicable disease outbreaks and other public health emergencies".

Dr Peter Carter, chief executive of the Royal College of Nursing, says:

"This fragmentation risks … preventing health providers from collaborating in the interests of patients. We must avoid a situation where existing NHS providers are left with expensive areas of care while private providers are able to 'cherry pick' the services which can be delivered easily".

But of course that is exactly what will happen with a level playing field, and the head start, the necessary head start, that the public NHS as a provider has always had—which is also, perhaps I may remind your Lordships, our head start, as the NHS belongs to us not private individuals—will be lost, and that services such as acute care, which I understand private providers do not like, will suffer.

Yesterday, the Royal College of General Practitioners published a survey saying that more than 70 per cent of respondents strongly agree, or agree, with proposals by some organisations and clinicians that this Bill be withdrawn. Seventy per cent said they did not wish to be on the board of a clinical commissioning group and a mere 4 per cent thought the reforms would lead to better care. It is also expected that a significant number of GPs who do not have the expertise, inclination or time will employ private companies to do the work, creating distance and adding to the financial drain. This—despite what the Government would clearly like the public and us to believe—is the true picture of medical professional opinion. How many more, then, do we need?

A major reason why we find ourselves in this situation now is that the movement towards privatisation did not of course start with the present Government but has been proceeding by degrees over long period of time; largely, it has to be said, unremarked upon by the public. In an article for the *London Review of Books* published on 22 September, James Meek says:

"The more closely one looks at what has happened over the last 25 years, the more clearly one can perceive a consistent programme for commercialising the NHS that is independent of party political platforms: a purposeful leviathan of ideas that powers on steadily beneath the surface bickering of the political cycle, never changing course".

One contemporary challenge of the National Health Service is how a degree of patient choice can be accommodated within it without greater competition being understood as its necessary corollary. I say "degree" because I wonder how much patient choice as an ideal has in fact been overplayed. Yes, it is right that you should have the option of seeing a different doctor if you have a bad relationship with the one you have been seeing; yes, you should be able to have a second opinion; and yes, you should be able to visit a different hospital if you had a bad experience at the first. By and large, however, I believe that what a patient wants is appropriate care and the guidance to achieve that—something that can only happen, surely, in an NHS based on mutual trust and co-operation rather than competition. Indeed, the Coalition of Medical Specialty Societies says,

"For the overwhelming majority of our patients, having access to high quality and suitable care is more important than choice".

Generally speaking, people do not want to travel across the country. A new article published in the *Lancet* by Alyson Pollock and others finds no evidence that patient choice saves lives. It noted that, given a multiple choice, patients choose the hospitals nearest to them.

When we had to rush our daughter to hospital with suspected meningitis a month after her early birth and just 48 hours after she had been allowed home, there was no choice involved. It was an instant snap judgment uninformed by outcomes, specialism or recommendations. We simply drove her to the nearest hospital, knowing instinctively that with acute care, time can be the most important factor in survival rate. However, if, through competition, the local hospital's A&E department has been shut or the whole hospital closed, there is going to be no choice anyway.

To acknowledge the long-term creeping movement toward privatisation could make those who support a public NHS highly pessimistic, but because this is the biggest leap yet towards full-scale privatisation, we are nevertheless at a crossroads where this trend could still

[The Earl of Clancarty]
be stopped in its tracks and even reversed, where we still have a chance to say "enough is enough". This is why I support first and foremost the amendment tabled by the noble Lord, Lord Rea. This is the NHS privatisation Bill. The public understand it as such and we should call it by that name and reject it.

11.56 pm

Lord Lucas: My Lords, the Royal College of General Practitioners should know better than to publish phooey surveys like that; they are supposed to understand what evidence-based medicine is. The same applies to polling: a random collection of self-selected GPs answering a poll online does not produce valid answers. But I will be just as rude about the Department of Health, which employed one poll to produce a similar low-quality piece of work and then trumpeted its results. We really ought to insist that a group of professionals who propose to believe in evidence-based medicine apply the same standards to their politics as they apply to their medicine.

There seems to be widespread acceptance that commissioning groups in one form or another are a good idea. I certainly share that view: I want my GP to have a real influence on the provision of care in the area where I live. I want my concerns and the concerns of his other patients to be reflected in the way that the NHS evolves locally. It seems to me that the structural changes we are looking at in this Bill largely flow from that change. If we are going to have real decision-taking at that sort of level, we have to push a good deal of power down from the Secretary of State.

I also accept what I think many other people agree with—that patient choice is important; that being able to choose between different remedies, different hospitals and different styles of doing things is important. I had a long view of hospitals in the course of my late wife's illness; it is astonishing, as the noble Lord, Lord Crisp, said, how variable care is. St George's Hospital had a wonderful ward for kidney patients; it had one of the worst wards I have ever encountered a few paces away. To be able to choose, to be able not just to suffer what is thrown at you but to have a voice in it, seems to be a very important part of the way that I would like my NHS to be.

If one is to have choice then—as the noble Lord, Lord Darzi, and others have pointed out—competition flows from that. You cannot have choice between two alternatives without those alternatives being in some way in competition with each other.

I think that the basics of this Bill flow from things that fundamentally we seem to agree with all around this House. I was very persuaded by the speeches of the noble Lords, Lord Warner and Lord Darzi, in that regard. There is a lot of common ground and I do not think that we should be too put off by the layer of political manure which the opposition Front Bench is attempting to spread on this. As the noble Lord, Lord Darzi, said, to believe in the NHS is to believe in the reform of the NHS—words which could well apply to this House in similar form—and I think that that is the basic understanding that we should approach this Bill with.

A lot of reservations have been expressed about detailed elements of this Bill, and listening to those who have expertise in those various areas, I am sure that I will take a close interest in them as we go through. There seems to be a lot of worthwhile discussion ahead. It is not clear to me, for instance, how integrated provision for people with complex needs is proposed to be dealt with under the structures that we have in the Bill. I have similar interests in how freedom of information will be dealt with in a health service with a much greater variety of providers, and I am keen to make sure that the structures encourage what one might call commissioning a community—getting the real community very much more involved in providing healthcare, looking after the elderly and looking after its own. That seems to me to be an expression of localism and community care that we ought to encourage and that ought to be possible once you get commissioning down to much more local entities than we have at the moment.

I do not know what the answer is to the question posed by the noble Lord, Lord Owen, about the Secretary of State's responsibility. He made a serious and thoughtful speech, as have others in this House, and I shall listen to the debates on that subject with great interest, but I do not see the argument for a separate committee to examine it. It seems to me to be a question which is deeply embedded in many aspects of this Bill, and I cannot see how we can separate discussion of it. I have been very impressed by the speeches that I have listened to today. I think that we have the expertise and understanding in this House to do justice to the questions that he raises. So I shall not be supporting his amendment or, indeed, that of the noble Lord, Lord Rea.

12.02 am

The Earl of Listowel: My Lords, I shall try to follow the contributions of the noble Baroness, Lady Hughes of Stretford, and the noble Baroness, Lady Massey of Darwen, who is chair of the All-Party Parliamentary Group on Children, in my remarks on children. Before I do so, I join other noble Lords in thanking the organisers of the helpful briefing meetings: the noble Baroness, Lady Thornton, and the Minister. I was most grateful for the opportunity to speak with the Minister last week and raise one of my concerns about the Bill with him.

I shall also refer briefly to the eloquent and powerful speech by my noble friend Lady Hollins, in which she raised concerns about how far we have to go in winning the hearts and minds of those in practice on the ground in the NHS. She also talked about the way that mental health in adults is so often overlooked and services for them are underdeveloped. I know that the Minister was very concerned when he recognised that 40 per cent of adults who smoke have a mental disorder and that there is a strong association between mental ill health and such pernicious self-harming behaviour. In a conversation following her speech, I checked with the noble Baroness that the aetiology—the roots—of much adult mental ill health begin in childhood. Personality disorders and depression are very often associated with difficulties in the earliest parts of childhood.

That reminds me of the utmost importance of effective early intervention with children and families and, most of all, of ensuring that parents are supported in building strong, consistent relationships with their children. Parents need support to be able to love their child. If they demonstrate their love for each other, the child will learn in later life to make those strong bonds. Also important, for example, are good perinatal care; good midwifery, with midwives engaging early with parents; and good health visitors.

I should declare an interest as a trustee of the Michael Sieff Foundation, a children's welfare organisation.

There is much that I can welcome in Her Majesty's Government's approach to the Bill. I should like to address the following: the importance of recruiting and retaining the best staff in the NHS; ensuring that the Bill helps to bring about effective early intervention with children and families and does not hinder it; and, finally, the need to pay particular attention to children with complex needs, as well as their families, and I include children looked after by local authorities.

I share the concern expressed by many of your Lordships today that the new commissioning arrangements hold the serious risk of leading to fragmentation of provision. We need to be very careful to avoid that.

I can say to the Minister that I have been immensely heartened by the approach that he and his colleagues have been taking to health visitors, teachers, social workers and others who are at the sharp end of caring for children. I admired and welcomed the section in the first Queen's Speech by this Government in which they called for more autonomy to be given to teachers, doctors and other professionals. I respect the principle enshrined in the Bill of empowering clinicians to manage their own work. I know therefore that the Minister will listen very carefully to the call from my noble friend Lord Walton of Detchant for careful consideration to be given to the future of the training and recruitment of doctors. I take that further. Today, we have heard concerns about unregistered carers. We need to ensure, through careful recruitment and good development and training, that people working in the NHS are of the very highest calibre. I hope that the Minister will allow the House to assist him in his work on this area, ensuring that the Bill provides what is needed.

The Government's White Paper on education and excellence in teaching and Professor Eileen Munro's final report on safeguarding children both recognised that the best outcome for our children can be achieved only by attracting and supporting the best candidates in social work and teaching. It is the sine qua non of success in these sectors and it seems to me to be equally applicable to health. I believe that this should go without saying, yet when one thinks of the plight of health visitors, the pressure on midwives, and the many health trusts in which staff consistently report poor support and morale, it needs to be said. It needs to be said when one thinks of the shortages of child and adolescent psychiatrists and the urgent need for more child mental health professionals. I look forward to working with the Minister and colleagues to ensure that the Bill delivers the best possible framework in which NHS staff can operate. I listened with care to the noble Lord, Lord MacKenzie of Culkein, on the issue of nurses. Unless we nurture our doctors and nurses, especially in this very difficult time, they will not be able to nurture the children, families and others in their care. One cannot be warm or show kindness if one does not feel valued and supported oneself.

I should now like to consider the importance of ensuring that the Bill promotes effective early intervention with children and families and does not hinder it. There are 11.8 million children in England, of whom about 65,000 are currently looked after by local authorities. I pay tribute to the vision of the Minister's colleague in the other place, the right honourable Iain Duncan Smith, in his work in promoting the cause of effective early intervention with families, his establishment of the Centre for Social Justice, his long work on and commitment to understanding the needs of vulnerable families, his bipartisan approach, and his close partnership with Graham Allen MP, the Labour Member for Nottingham North.

The coalition Government have commissioned important reports from Dame Clare Tickell, Dr Eileen Munro, Graham Allen MP and Frank Field MP, among others, and have instituted the family law review. Breaking the cycle of deprivation by effective early intervention is, as I understand it, a cause at the core of this Government's endeavours and I look forward to working with the Minister and colleagues to ensure that this Bill meets the Government's own high ambitions in this area.

I have been reminded that the Kennedy report highlighted the relative neglect of services to children and families in the NHS. The Nicholson challenge poses the risk that these vital services may be further undercut if they continue in this state of relative neglect. For the sake of the future of these children and the future productivity of this nation, who will pay for the care of all the elderly who are accruing now and will accrue in the future? We must ensure that the culture within the NHS changes. We must prioritise children and families more. I hope the Minister will be prepared to further strengthen the position of children and families in this Bill, in particular by including them in the mandate of the NHS commission.

My third theme is the need for a seamless inter-agency service for children with complex needs. Children must not fall down the cracks between services.

I will stop at this point. I reiterate that we need to put into practice the theme of early intervention. It is key. So much work has been done on it and we can use that in this Bill to make a real difference to children and families—a real difference to the future of this country.

12.11 am

Lord Collins of Highbury: My Lords, I am very aware that my contribution has been eagerly awaited by all noble Lords who are still here. As the 85th speaker, and the last tonight, I suspect that it is not its content but its end that is desired most. Therefore, I promise not to go on too long.

After reading hundreds of e-mails from both users and providers of the NHS, and having listened carefully to the debate so far, I remain of the view that was ably expressed by my noble friend Lady Thornton this

[Lord Collins of Highbury]
morning when she said that in making these top-down changes to our NHS, this coalition Government have no mandate, no evidence and no support. Like many in this House, I do not want a health service that stands still. I was, and remain, a keen supporter of the health policies of the last Labour Government which, as my noble friend Lord Warner reminded us, were identified in our manifestos in 2001 and 2005, and on which we won.

The change agenda then was to deliver the best outcomes for the patient and best value for taxpayers. I fear that the changes proposed in this Bill, despite what the Minister states, will not improve care for the patient and will be extremely costly to taxpayers. The worthy aims expressed by the Minister are not the issue. As we have heard many times throughout this debate, the aims can be achieved without a major high-risk, high-cost reorganisation of the NHS.

My fear—I think that this is shared by many—is that ideology drives the promoters of the Bill. It is an ideology that sees a competitive free market as the way to deliver healthcare efficiently. As the noble Lord, Lord Owen, said, this is not a model supported by the British public. I do not often find myself agreeing with the noble Lord, but I thought that he was spot on when he explained why the NHS had so much support from the British public: it is because, in the distribution of resources, it is fair.

For me, modernisation of the health service was, and is, about addressing unacceptable variation in standards; inequality; lack of integration—vertically and horizontally; the fixation with acute care rather than better primary care; and more investment in prevention and public health.

My real concern is that I do not see this Bill as being helpful in addressing these key issues. In fact, I see a Bill that will cause fragmentation rather than integration. It is in this context that I wish to raise three specific issues, which I hope to address further in the event that my noble friend's amendment is not carried tomorrow.

First, on public health, while I accept and agree that the transfer of public health functions to local authorities creates the potential for better alignment with other responsibilities and other issues—we have heard mention in the debate of housing, environment and education—that will not happen unless directors of public health are in a position to shape policy in these areas. I along with many others fear that the Government's response to the NHS Future Forum offers no further clarity over the role, status and work of directors of public health.

Secondly, on HIV and the role of prevention and treatment, the House of Lords Select Committee report on HIV in the UK, chaired by the noble Lord, Lord Fowler, identified that more than a quarter of those infected have not been diagnosed and are unaware of their condition. This affects the individual concerned and spreads the disease further. Better testing must be a priority. The committee proposed routine testing for all new patients at GP surgeries and general medical admissions beginning in areas where the prevalence of HIV is highest. It also proposed the legalisation and regulation of home testing.

Spending on prevention is seriously inadequate. HIV is entirely preventable, but the latest figures show that the Government spent only £2.9 million on national prevention programmes, compared with £762 million on treatment. My concern with the Bill is the disconnect in planning between prevention and treatment, plus the strong probability that public health budgets will be severely limited, leading to even further underfunded prevention campaigns. There needs to be better investment in evidence-based HIV prevention work to prevent the treatment bill rising even further.

I turn finally to diabetes. The noble Earl the Minister knows that, last week in the debate on non-communicable diseases, I "came out" as a type 2 diabetic. My condition has been caused, as I am repeatedly reminded in the media and even by some noble Lords in the House, by my bad lifestyle as a former smoker and a person who eats too much—that is fair enough. However, as a result of NHS provision, I am now very much aware that diabetes is a complex and lifelong condition.

My regular testing and treatment, comprising GP surgery, podiatry clinic, retinal screening, specialist eye clinic and dietician, is a perfect example a pathway of services where primary, secondary and community healthcare and social care are integrated around my needs. My early diagnosis and this integrated pathway of care will keep me free of the worst and most costly consequences of this disease.

Although the amended Bill requires the NHS Commissioning Board and clinical commissioning groups to promote integration, Diabetes UK, which has given me excellent support, proposes that to strengthen this vital duty the NHS Commissioning Board and clinical commissioning groups must report annually on how they are fulfilling their duty to promote integration.

The Government have stated that they are committed to the principle of "no decision about me without me" and there is substantial evidence about the benefits of patient involvement on health outcomes, something that I know only too well.

Diabetes UK believes that the Bill should be further improved by defining the involvement of individual patients and their carers in decisions relating to their own care and treatment. In addition, collective patient, patient organisation and carer expertise must be central to commissioning decisions and service design through the introduction of an overarching principle of co-design in the commissioning of care pathways.

It is essential that this collective experience and knowledge is used in the design and commissioning decisions to gain the benefit of the experiences of a wide range of patients, not simply a small number of individuals. The Secretary of State of Health has said that,

"integration around the needs of patients trumps other issues, including the application of competition rules",

yet it is not clear from the Bill that that is the case. The Bill has been amended with a duty laid on Monitor to exercise its function to enable services to be provided in an integrated way. However, the balance still appears to be in favour of competition over integration.

One big concern for me is that the need to demonstrate that competition requirements have not been infringed will drive elements of the diabetes care pathway to be

opened to competition and will be fragmented. It will not be the joined-up treatment and understanding of the podiatrist knowing what the dietician is advising. It will break the trust between elements of the pathway over time. I understand from Diabetes UK that there are discussions currently about the possibility of integrated pathways being commissioned rather than individual parts of the pathway. But it is suggested that this could happen only if the whole pathway was subject to competition. Diabetes UK believes that this is impracticable and so do I, and I urge the noble Earl in his reply to outline clearly how integrated pathways will be commissioned.

Debate adjourned until tomorrow.

House adjourned at 12.23 am.

Written Statements

Tuesday 11 October 2011

Care Homes: Southern Cross

Statement

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My honourable friend the Minister of State, Department of Health (Paul Burstow) has made the following Written Ministerial Statement.

I wish to update the House on Southern Cross and the Government's wider response to the issues which this case has raised.

On 30 September, Southern Cross announced that 250 of the care homes in which it operates have been transferred to new care operators. This represents one-third of all of Southern Cross's homes, involving 249 homes in England and one in Scotland. In each case, the transfer was scrutinised and approved by the relevant national regulator. For the time being, Southern Cross will continue to provide care services in the remainder of its homes.

Two further transfers of homes are expected in October and when the transfers are concluded Southern Cross will no longer be a provider of care services.

The Association of Directors of Adults Social Services is maintaining a list of Southern Cross's care homes with information on plans for transfer to alternative providers, as well as contact information for residents, relatives and any other interested parties. This is updated weekly and is available at: www.dh.gov.uk/health/2011/09/transfer-of-southern-cross-healthcare-to-new-operators/.

This first set of transfers is an important step towards the consensual and orderly winding down of the company. Throughout, it has been the Government's overriding concern to secure the welfare and safety of the residents in Southern Cross's care. This transfer and the ones to follow should ensure that this is achieved, with minimal impact on the residents of these homes and clear arrangements to ensure continuity of care.

We will continue to monitor closely the remaining steps to the full transfer of all homes, and will work closely with all interested parties, but I am encouraged that those involved in the restructuring negotiations have put in place the necessary agreements to secure a successful outcome.

As noted by the National Audit Office in its recent report on the social care market, *Oversight of User Choice and Provider Competition in Care Markets*, the case of Southern Cross has highlighted the risks associated with a large care provider facing financial difficulty.

In my previous Written Ministerial Statement to Parliament, I said the Government would shortly be publishing a discussion paper on the issue. This paper has been published today, and forms a part of the Government's wider engagement exercise on care and support reform, as reported to the House on 15 September 2011.

The paper considers the issues raised by the risk of financial failure in large providers and seeks views on service continuity and or whether new measures are necessary. It sets out what the Government think is the key objective of any reform, and outlines the key considerations that need to be balanced when coming to a view on what measures may be appropriate. It then lists a range of possible options that could be pursued, drawing on experience in other sectors and considering both regulatory and non-regulatory approaches. This includes possible roles for Monitor, as allowed for in the Health and Social Care Bill, which is currently before the House. The paper invites comments on these options, but also welcomes other ideas. At this stage the Government have not formed a firm view on what would be the best approach. They want to take this opportunity to hear different views before settling their position ahead of next years White Paper.

The *Oversight of User Choice and Provider Competition in Care Markets* discussion paper has been placed in the Library. Copies are available to honourable Members from the Vote Office and to noble Lords from the Printed Paper Office.

Control Orders

Statement

The Minister of State, Home Office (Lord Henley): My right honourable friend the Secretary of State for the Home Department (Theresa May) has today made the following Written Ministerial Statement.

Section 14(1) of the Prevention of Terrorism Act 2005 (the 2005 Act) requires the Secretary of State to report to Parliament as soon as reasonably practicable after the end of every relevant three-month period on the exercise of the control order powers during that period.

The level of information provided will always be subject to slight variations based on operational advice.

The future of the control order regime

The Terrorism Prevention and Investigation Measures (TPIM) Bill, which makes provision for the abolition of control orders and their replacement with a new, less intrusive and more focused regime, is continuing its parliamentary passage. A copy of the Bill can be found on Parliament's website. The home page for the Bill is: http://services.parliament.uk/bills/2010-11/terrorismpreventionandinvestigationmeasures.html.

The control order system will continue to operate until its replacement is in force.

The Government's counterterrorism and security powers review concluded that there may be exceptional circumstances where more stringent measures may be required to protect the public than those available under the TPIM Bill. Such circumstances would be a very serious terrorist risk that cannot be managed by any other means. The Government committed to preparing draft emergency legislation for introduction should such circumstances arise. The draft enhanced TPIM Bill was published on 1 September so that it can be subject to pre-legislative scrutiny.

The exercise of the control order powers in the last quarter

As explained in previous quarterly statements, control order obligations are tailored to the individual concerned and are based on the terrorism-related risk that individual poses. Each control order is kept under regular review to ensure that the obligations remain necessary and proportionate. The Home Office continues to hold Control Order Review Groups (CORGs) every quarter, with representation from law enforcement and intelligence agencies, to keep the obligations in every control order under regular and formal review and to facilitate a review of appropriate exit strategies. During the reporting period, one CORG was held in relation to some of the orders in force at the time. CORGs in relation to the remaining cases were held just before this reporting period. Other meetings were held on an ad-hoc basis as specific issues arose.

During the period 11 June 2011 to 10 September 2011, no non-derogating control orders were made or served. Two control orders have been renewed in accordance with Section 2(6) of the 2005 Act in this reporting period. One control order was revoked during this reporting period as it was no longer considered necessary. One control order, made in a previous quarter but never served, expired during this reporting period.

In total, as of 10 September, 11 control orders were in force, all of which were in respect of British citizens. All these control orders were non-derogating. One individual subject to a control order was living in the Metropolitan Police District; the remaining individuals were living in other police force areas.

Three individuals were charged with breaching their control order obligations during this period.

During this reporting period, 76 modifications of control order obligations were made. Twenty-two requests to modify control order obligations were refused.

Section 10(1) of the 2005 Act provides a right of appeal against a decision by the Secretary of State to renew a non-derogating control order or to modify an obligation imposed by a non-derogating control order without consent. Two appeals have been lodged with the High Court during this reporting period under Section 10(1) of the 2005 Act. A right of appeal is also provided by Section 10(3) of the 2005 Act against a decision by the Secretary of State to refuse a request by a controlled person to revoke their order or to modify any obligation under their order. During this reporting period no appeals were lodged with the High Court under Section 10(3) of the 2005 Act.

Seven judgments have been handed down in relation to control order cases during this reporting period; five by the High Court and two by the Court of Appeal.

On 13 June 2011 a judgment was handed down by the High Court in relation to the appeal brought by BG under Section 10(1) of the 2005 Act. In BG v Secretary of State for the Home Department [2011] EWHC 1478 (Admin), the High Court upheld the Secretary of State's decision.

On 18 July 2011 the High Court handed down a judgment following the court review of the imposition of a control order under Section 3(10) of the 2005 Act. In Secretary of State for the Home Department v BF [2011] EWHC 1878 (Admin) the High Court upheld the decision to make the control order.

On 22 July 2011, the High Court handed down a judgment in relation to an appeal by a controlled individual under Section 10(3) of the 2005 Act. In BM v Secretary of State for the Home Department [2011] EWHC 1969 (Admin), the High Court upheld the Secretary of State's decision.

The High Court handed down a further judgment on 25 July 2011 in relation to two individuals who were each subject to control orders for only a short period of time. In Secretary of State for the Home Department v CB and BP [2011] EWHC 1990 (Admin), the court ruled that it was appropriate for it to exercise its case management powers to in effect terminate the court review of the imposition of their control orders. The court also ordered the discharge of the anonymity orders made in these cases. Abid Naseer (CB) and Faraz Khan (BP) have been granted permission by the High Court to appeal the decision to terminate the court proceedings.

On 29 July 2011 the High Court handed down a judgment following the court review of the imposition of a control order under Section 3(10) of the 2005 Act. In Secretary of State for the Home Department v CD [2011] EWHC 2087 (Admin), the High Court upheld the decision to make the control order.

The first judgment handed down by the Court of Appeal in this reporting period relates to the appeal brought by AM against the decision of the High Court to uphold his control order. In AM v Secretary of State for the Home Department [2011] EWCA Civ 710, handed down on 21 June 2011, the Court of Appeal dismissed AM's appeal.

The Court of Appeal also handed down judgment in this reporting period in the context of the appeal brought by AH, an individual formerly subject to a control order. In AH v Secretary of State for the Home Department [2011] EWCA Civ 787, handed down on 6 July 2011, the Court of Appeal dismissed AH's appeal.

Most full judgments are available at http://www.bailii.org/.

Criminal Justice: Access to Lawyers

Statement

The Minister of State, Ministry of Justice (Lord McNally): My right honourable friend the Lord Chancellor and Secretary of State for Justice (Kenneth Clarke) has made the following Written Ministerial Statement.

The Government have decided not to opt in at this stage to the directive on the right of access to a lawyer in criminal proceedings and on the right to communicate upon arrest.

The Government have taken this decision in accordance with the commitment in the coalition agreement, which states that we will approach legislation in the area of criminal justice on a case by case basis, with a view to

maximising our country's security, protecting Britain's civil liberties and preserving the integrity of our criminal justice system.

The Government agree that a European directive in this area is a good idea in principle. We believe that it could benefit UK nationals who become subject to the criminal justice systems of other member states. Such a directive could also build greater trust and confidence among the competent authorities of all EU member states who may be expected to accept and act upon decisions or judgments made in other member states. However, a number of provisions in the proposal, as published by the European Commission, go substantially beyond the requirements of the European Convention on Human Rights (ECHR) and would have an adverse impact on our ability to investigate and prosecute offences effectively and fairly. Given the extent of our concerns on the detail of this directive, we cannot at this stage be confident that all of them will be addressed in the process of negotiations.

Given the importance we attach to the principles of this directive, we intend to work very closely with our European partners to develop a text that takes greater account of the practical realities of the investigation and prosecution of crime and reflects the flexibility which member states need in order to the meet the requirements of the ECHR in a way that is consistent with the nature of their justice systems. In the event that our concerns about the initial draft of the directive are satisfactorily dealt with during the negotiations, we will give serious thought to whether we should apply to opt in to it once it has been adopted, as our protocol to the Treaty on the Functioning of the European Union allows. We will consult Parliament about any decision to apply to opt in to the final text.

Defence Vetting Agency

Statement

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever): My right honourable friend the Minister for Defence Personnel, Welfare and Veterans (Mr Robathan) has made the following Written Ministerial Statement.

As part of the programme of work associated with defence reform within the Ministry of Defence (MoD) the Defence Vetting Agency (DVA) ceased to have the status of an executive agency from 1 October 2011.

The DVA was formed in April 1997, bringing together the four national service vetting (NSV) organisations serving each of the Armed Services and the MoD. Since that date the DVA has successfully delivered NSV services to the MoD and its industry contractors, and has also provided similar services to a wide range of other government departments. Today it is by far the larger of the two UK Government-shared service providers of NSV.

My right honourable friend the Secretary of State for Defence announced on 22 March 2011 (*Official Report*, cols. 49-50 *WS*) the intention to establish a new defence business services (DBS) organisation, bringing together the delivery of a range of corporate service functions to support all areas of the department from one organisation. The DBS was launched in July, and the NSV function undertaken by the DVA will be provided under a new business model renamed as DBS National Security Vetting.

This change in operating status will have no impact on the DVA's customers, and will deliver efficiencies and wider savings to government. In particular, it will reinforce the DVA's ability to deliver planned business improvements from its new Cerberus IT system to drive up service to its internal and external customers.

Energy: Nuclear Power

Statement

The Parliamentary Under-Secretary of State, Department of Energy and Climate Change (Lord Marland): My right honourable friend the Secretary of State for Energy and Climate Change (Chris Huhne) has made the following Written Ministerial Statement.

Today I have deposited in the House the final report which I requested from the chief nuclear inspector, Dr Mike Weightman, on the events at Japan's Fukushima Dai-chi nuclear site in March.

Fukushima changed the energy debate around the world. Questions were raised about the extent and safety of nuclear power, and people rightfully wanted to know what happened and whether it could happen again.

Safety is always our number one concern. We needed to understand the facts before making any decisions. That is why I asked the chief nuclear inspector, Dr Mike Weightman, to look at what Fukushima means for nuclear energy in Britain and at what lessons can be learnt.

Dr Weightman produced his interim report in May. It was evidence-based, and prepared in close co-operation with international regulators. It confirmed that the UK's current safety regime is working, and that regulators and industry should continue to work together to make continuous improvements to nuclear safety.

The interim report also reassured us that new nuclear can be part of a low-carbon energy mix in the UK. Nuclear energy is important for our energy security now and we want it to be part of the mix in the future.

Dr Weightman's final report was submitted to me on 30 September, and I am presenting it to the House at the earliest possible opportunity.

I would like to thank Dr Weightman and his team for their hard work. This is a thorough and comprehensive report on the lessons that can be learnt for the UK's nuclear industry. It will help ensure that our regulatory regime remains robust, and that the nuclear industry remains committed to continuous improvement for all existing and future facilities.

The final report expands on the interim report by providing additional information and evidence, widening the scope to include non-generation sites in the UK, such as Sellafield.

It provides background on how to mitigate against radioactive hazards; the differences between reactor technologies in Fukushima and the UK; and the differing approaches to nuclear safety and security in the UK, Japan and the wider world.

The report also sets out a timetable of events at Fukushima, and describes the work undertaken by Dr Weightman and his team.

One of the report's key findings is that the additional information received since the interim report, including from his own visit to Fukushima and the UK Office for Nuclear Regulation's own more detailed analysis, has reinforced the interim findings.

As the initial report made clear, the current regulatory safety framework in the UK is satisfactory. Dr Weightman sees no reason to curtail the operation of power plants or other nuclear facilities in the UK. He believes the industry has reacted responsibly and appropriately, displaying strong leadership for safety and safety culture.

The final report re-states these interim conclusions and recommendations. It also concludes that the UK practice of periodic safety reviews of licensed sites provides a robust means of ensuring continuous improvement in line with advances in technology and standards.

The final report also emphasises the need to continue the Sellafield legacy pond and silo cleanup with the utmost vigour and determination.

The Nuclear Decommissioning Authority is making tangible, demonstrable progress in addressing these national priorities. It is the NDA's top priority, and we have ensured that their work in this area is not limited by funding constraints. Reduction of risk and hazard sits at the very heart of the NDA's mission.

Dr Weightman and his team are satisfied with the responses and actions initiated by government and industry in response to the interim report.

The final report also re-states the recommendations from the interim report, adding additional detail where necessary. It focuses on areas that should be reviewed to determine whether further practicable improvements can be made to enhance safety.

Dr Weightman has also recommended that regulators, government and industry:

review the UK's ability to monitor and provide real-time information in an emergency;

review the robustness of emergency control structures and systems; and

continue to promote high levels of safety culture, making use of the National Skills Academy for nuclear and other nuclear professionalism schemes.

The final report also confirms the advice given by Dr Weightman at the time of the interim report: namely that he saw no reason to revise the strategic advice on which the nuclear national policy statement was based, or any need to change present siting strategies for new nuclear power stations in the UK.

Dr Weightman's final recommendation is to invite reports on progress by June 2012, when he intends to report back on implementation lessons.

The European nuclear stress tests have been conducted in parallel to this process, and there are overlaps between the initial findings and the recommendations in Dr Weightman's reports. Stress testing will continue into next year, and both industry and the Office for Nuclear Regulation will continue to be involved. Dr Weightman's proposed supplementary report will include further details of the stress test.

Regulators and industry are also continuing to work together to take forward the generic design assessment process for new nuclear reactors, and have extended their timeline in order to take into account the findings in both the interim and final report. Regulators have stated that they hope to be in a position to take decision on the generic design assessment by the end of the year.

In conclusion, I welcome Dr Weightman's final report, and I encourage the regulators to work closely with industry and other partners to take the recommendations forward. The Government intend to respond to Dr Weightman's recommendations in more detail by the end of the year.

Olympic Games 2012

Statement

Baroness Garden of Frognal: My honourable friend the Parliamentary Under-Secretary of State for Culture, Olympics, Media and Sport (Hugh Robertson) has made the following Written Ministerial Statement.

Further to the Written Statement made to the House on 3 March 2011 referring to the selection of the preferred bidder for the long-term lease of the Olympic Stadium, my colleague the Parliamentary Under-Secretary of State for Communities and Local Government, the Mayor of London and I have today decided, as joint founder members of the Olympic Park Legacy Company (OPLC), that the company should terminate the process for the disposal of the Olympic Stadium with immediate effect.

The OPLC founder members have also agreed that the company should now explore alternative options in order to deliver the stadium in legacy, and take into account the commitments that have recently been made in support of the bid to host the World Athletics Championship in 2017.

This decision will remove the ongoing uncertainty and continuing delays in determining a sustainable legacy for this important part of the legacy of the Olympic Park.

Social Security (Categorisation of Earners) Regulations 1978

Statement

The Commercial Secretary to the Treasury (Lord Sassoon): My honourable friend the Exchequer Secretary to the Treasury (David Gauke) has today made the following Written Ministerial Statement.

On Friday 7 October, HM Revenue and Customs published a consultation on the Social Security (Categorisation of Earners) Regulations 1978 in relation to lecturers, teachers, instructors or those in a similar capacity. Its purpose is to consult on HMRC's proposal to repeal this part of the regulations.

The consultation document is available on the HM Revenue and Customs website at: http://www.hmrc.gov.uk/consultations/.

Vehicles: Semi-trailers

Statement

Earl Attlee: My right honourable friend the Parliamentary Under-Secretary of State for Transport (Mike Penning) has made the following Ministerial Statement.

Further to my Statement of 30 March 2011 (*Official Report*, col. 23 *WS*), the Department for Transport has today published its response to the consultation on a proposal to allow a 2.05-metre increase in the length of semi-trailers and a maximum overall length for articulated heavy goods vehicles of 18.75 metres.

The research underlying the consultation proposal suggests that high volume semi-trailers have potential environmental, safety and congestion benefits; they would allow up to 13 per cent more loading space than current articulated lorries, resulting in fewer journeys needed to transport the same volume of goods. The research predicts that by 2015 this would reduce lorry miles in the UK by 100 million to 180 million a year, meaning reduced congestion, reduced air pollution and reduced carbon emissions (a reduction of around 100,000 tonnes a year). The research also found that there would be a net decrease in casualties of around 1.6 per cent from the reduction in lorry miles.

However, the evidence provided during the consultation exercise has identified a number of areas that merit additional investigation. These include possible effects if the number of longer semi-trailers introduced is significantly higher than that predicted by the research and the impact assessment attached to the consultation document; the impacts of longer semi-trailers on road infrastructure and design and on depot and distribution centre infrastructure and design; the impacts on SMEs of allowing longer semi-trailers; and the effectiveness of additional vision/sensor/safety systems fitted to improve detection of vulnerable road users.

The research underlying the consultation proposals was comprehensive. To gather further evidence on such impacts will therefore require a trial of longer semi-trailers in operation. The department therefore intends to proceed with an operational trial of longer semi-trailers in order to gather practical evidence. Trailers taking part in the trial will operate under vehicle special orders issued under Section 44 of the Road Traffic Act 1988.

The department considers that the number of vehicles permitted in the trial will need to be limited, but that the number permitted should still allow meaningful evidence to be gathered on the likely take-up of longer semi-trailers across the vehicle fleet as well as their impact on infrastructure. This would require a trial of vehicle numbers that allows operators to swap a sufficient percentage of their fleet over to the longer semi-trailer to enable them to remove standard trailers from their fleet and make an effective comparison of performance.

The responses to the consultation also indicate that different businesses would wish to choose between additional trailer lengths of up to 1 metre and 2.05 metres, depending on the nature of their business. The trial provides an opportunity to validate the impacts of each length. The current trailer park for articulated vehicles above 40 tonnes in the UK is estimated at around 100,000 trailers. The department intends to proceed with a trial of up to 900 trailers of an increased length of up to 2.05 metres; and 900 trailers of an increased length of up to 1 metre, 1,800 trailers forming just under 2 per cent of trailers on British roads.

Our baseline research shows that the ability to operate longer semi-trailers would provide clear benefits to business and a spur to efficiency and growth. We expect the trial itself to offer a net present value of £33 million, largely due to the financial benefits operators should see over the 10-year length of the trial (around £1,800 per vehicle per year). We would expect many of these benefits to flow through to the consumer.

Participation in the trial will be on a voluntary basis and at the participants' own risk; there is no guarantee that the use of the longer semi-trailers will continue to be permitted beyond the end of the trial period. The trial will run for 10 years to allow those businesses wishing to participate the opportunity to cover the costs of investment in the longer semi-trailers. Expressions of interest are invited from today, with the trial starting in January 2012. Information on how to apply can be found on the DfT website.

However, the department wishes the trial to be closely monitored to ensure that any significant issues that arise, particularly on safety, are addressed quickly and that the trial is meeting the department's objectives. The department will therefore appoint an independent contractor to monitor and review trial progress. The contractor will report to the department on a four-monthly basis; at the end of each trial year the department will review progress towards objectives, including considering any changes to the length of the trial and the numbers of trailers involved in the trial.

Although many of the responses from vehicle operators supported the development of tractor units with a safer, more aerodynamic frontal design, it was evident from the majority of responses received from vehicle manufacturers that they are unlikely to progress with the development of improved frontal designs at this time. Therefore, the department has decided not to include tractor units with an extension of up to 0.4 metres for improved frontal designs in the trial. However, we are keeping the situation under review.

Written Answers

Tuesday 11 October 2011

Airports: Heathrow

Questions

Asked by ***Lord Bowness***

To ask Her Majesty's Government why the passport gates for holders of e-passports at Heathrow Airport are not kept operational at all times. [HL12211]

The Minister of State, Home Office (Lord Henley): The e-passport gates at Heathrow are open between 6 am and 10 pm every day. Outside those hours the demand is considerably less so it is not economic to have them open. The only other reason for e-passport gates being non-operational is where there is a technical problem.

Asked by ***Lord Bowness***

To ask Her Majesty's Government whether the UK Border Agency staffs sufficient immigration desks to deal with the number of European Union and European Economic Area passport holders arriving at London Heathrow. [HL12212]

Lord Henley: The UK Border Agency at Heathrow deploys staff flexibly to meet its published service standards. For the European Union and the European Economic Area that is 95 per cent of passengers cleared within 25 minutes. This standard is met at Heathrow.

Bat Khurts

Question

Asked by ***Viscount Waverley***

To ask Her Majesty's Government what is the estimated cost of the arrest, detention, appeals process and extradition to Germany of Mr Bat Khurts, a Mongolian citizen; and whether they have plans to make an approach to the Government of Germany to contribute to those costs. [HL12123]

The Minister of State, Home Office (Lord Henley): A complete or accurate breakdown of costs incurred in this case is not held centrally. This is because a number of departments and agencies are involved in the extradition process, including the Home Office, the Foreign and Commonwealth Office, the Serious Organised Crime Agency, the Crown Prosecution Service, the police and HM Courts and Tribunals Service.

However, the Home Office is currently undertaking an exercise to estimate the cost of the extradition process and these estimates will be available in due course.

Under the terms of the framework decision on the European arrest warrant, all costs incurred in executing a warrant shall be borne by the executing state. All other costs, such as compiling and translating the warrant and the cost of collecting and transporting the person back to the issuing state are borne by that state.

China

Question

Asked by ***Lord Soley***

To ask Her Majesty's Government, further to the Written Answer by Earl Attlee on 11 August (*WA 381–82*), what response they gave to representatives of the Government of China, Chinese airlines, and the Deputy Administrator of the Civil Administration of China at the meetings and discussions referred to in the Answer. [HL12253]

Earl Attlee: On both occasions government officials explained how the independent slot allocation process works in the UK and the options available to airlines seeking slots at UK airports.

At the round of formal UK/China air services negotiations in April, the Chinese delegation was also able to meet representatives from a number of UK airports. They received a presentation on the slot allocation process from Airport Co-ordination Limited (ACL), the independent body responsible for slot allocation, schedules facilitation and schedule data collection at a large number of UK airports.

Drugs: Pyridostigmine Bromide

Questions

Asked by ***Lord Morris of Manchester***

To ask Her Majesty's Government what is the age profile of civilians prescribed with pyridostigmine bromide (PB) compared with that of members of the Armed Forces who were required to take PB during the first Gulf War. [HL12167]

To ask Her Majesty's Government what is the usual duration of the treatment period for civilians prescribed pyridostigmine bromide. [HL12168]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): Information on the age of National Health Service patients prescribed a medicine is not collected centrally, so no meaningful comparison can be made.

It is for the prescribing clinician to decide for how long a patient should be prescribed a particular medicine, taking into account the patient's individual circumstances. Information on the usual duration of the treatment period for civilians prescribed pyridostigmine bromide is not collected centrally.

Energy: Carbon Reduction

Question

Asked by ***Lord Hunt of Chesterton***

To ask Her Majesty's Government how they intend to keep under review and publicise their future plans for different types of non-carbon energy supply in relation to the likely carbon savings and costs of those systems. [HL12208]

The Parliamentary Under-Secretary of State, Department of Energy and Climate Change (Lord Marland): The Government will use a combination of statutory and other publications to give insight into their future plans for different types of non-carbon energy supply and the likely carbon savings and costs of those systems. These are: the government response to the annual progress report by the Committee on Climate Change, which will be published by 15 October at the latest; the updated emission projections; the report on the estimated impacts of energy and climate change policies on energy prices and bills; and the annual energy statement, which this year will take the form of an Oral Statement to Parliament.

Housing Benefit

Question

Asked by ***Baroness Scott of Needham Market***

To ask Her Majesty's Government what percentage of council house tenants are in receipt of housing benefit. [HL12125]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): Housing benefit recipients, local authority tenants, as a percentage of local authority dwellings stock—June 2011

	HB LA caseload as a percentage of LA households
Great Britain	64.9

Source: Single Housing Benefit Extract (SHBE).

Households data source is the HSSA annual return submitted by each local authority.

Notes:

1. The percentage has been rounded to one decimal place.

2. Housing benefit recipients are based on benefit level and not household and as such may include more than one person at the same address who claim independently.

3. Percentages have been calculated using household statistics for LAs (2009) published at: http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/stockincludingvacants/livetables/

4. SHBE is a monthly electronic scan of claimant level data direct from local authority computer systems. It replaces quarterly aggregate clerical returns.

Immigration

Question

Asked by ***Lord Tebbit***

To ask Her Majesty's Government whether net immigration has fallen since they came into office. [HL11957]

The Minister of State, Home Office (Lord Henley): Provisional Office for National Statistics estimates of long-term international migration show that net migration fell from 242,000 in the year ending September 2010 to 239,000 in the year ending December 2010.

Legal Aid, Sentencing and Punishment of Offenders Bill

Questions

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what assessment each government department has made of the costs that will be incurred to each department and its agencies as a result of the provisions of the Legal Aid, Sentencing and Punishment of Offenders Bill. [HL11775]

The Minister of State, Ministry of Justice (Lord McNally): The impact assessment published alongside the Government's response to consultation lays out the best estimates of the costs and benefits of the legal aid reforms. Extensive discussions were also held with other government departments as part of the policy development and clearance process, which included discussions on systemic costs. Ultimately, costs to other departments will be driven by behavioural responses to the changes, and these are very difficult to predict with any real degree of accuracy.

Asked by ***Lord Lester of Herne Hill***

To ask Her Majesty's Government how they intend to ensure that the means-testing of arrestees prior to accessing legal advice, as proposed in the Legal Aid, Sentencing and Punishment of Offenders Bill, will be compatible with the common law and the European Convention on Human Rights right to legal advice on arrest. [HL11786]

Lord McNally: There are no current plans to change the present system that operates in practice for police station advice. It is currently intended that initial advice and initial assistance at the police station (or for those held in custody at other premises) should continue to be available to all those to whom it is available at the moment. The provisions in the Bill would also allow for the introduction of means-testing in future, although there are no current plans to do so.

Olympic and Paralympic Games 2012

Question

Asked by ***Lord Maginnis of Drumglass***

To ask Her Majesty's Government what consideration they gave to the spirit of the Olympic Games by implementing decisions that prevent entrants from the Turkish Republic of Northern Cyprus from participating in the Olympic Games and Special Olympics; and to what extent they consider that politics should impact on sport in the United Kingdom. [HL12017]

Baroness Garden of Frognal: The rules governing arrangements for competing at the Olympic and Paralympic Games are a matter for the International Olympic Committee (IOC) and not Her Majesty's Government. The Turkish Republic of Northern Cyprus is not recognised by the United Nations and does not have a National Olympic Committee recognised by the IOC.

Qualifying athletes who consider themselves to be affiliated to the self-declared Turkish Republic of Northern Cyprus are not prevented from competing at the Olympic and Paralympic Games. Such athletes are free to compete under the flag of a National Olympic Committee recognised by the IOC for which they hold a passport.

Overseas Farming

Question

Asked by ***Lord Judd***

To ask Her Majesty's Government what priority the Department for International Development accords to (a) the encouragement of smallholder agriculture, and (b) equal access to agricultural production resources for male and female farmers. [HL12106]

Baroness Northover: Smallholder agriculture is an important element of at least 12 of our bilateral aid programmes and of relevant multilateral work funded by DfID, such as our programmes with the International Fund for Agricultural Development. The new DfID gender vision places an emphasis on empowering girls and women. This includes strengthening their access to economic assets and maximising what has been proven to work. For women farmers this means specifically strengthening their access to productive inputs, finance and gender-aware extension services. In Rwanda, DfID is helping communities agree land ownership rights among themselves so that 6.4 million people—half of whom will be women—will have formal title to their land.

People Trafficking

Question

Asked by ***Lord Sheikh***

To ask Her Majesty's Government whether they plan to put measures in place to increase public awareness of human trafficking. [HL12092]

The Minister of State, Home Office (Lord Henley): The Government's strategy on human trafficking sets out the commitment to explore what further role the public can play in identifying information about trafficking; and to raise awareness and vigilance in particular communities.

The Home Office is working with other government departments and non-governmental organisations to identify what more can be done to increase public awareness of human trafficking, both in the UK and overseas.

Police: Annual Leave

Question

Asked by ***Lord Adonis***

To ask Her Majesty's Government, further to the Written Answer by Baroness Browning on 6 September (*WA 27*), in the absence of centrally collected data on police leave, (a) at what level these data are collected, and (b) to whom inquiries should be directed to elicit the required information. [HL11713]

The Minister of State, Home Office (Lord Henley): Information showing Metropolitan Police officers on leave for any particular day is not collected by the Home Office. It is a matter for the Commissioner of the Metropolitan Police.

Railways: Procurement

Questions

Asked by ***Lord Chidgey***

To ask Her Majesty's Government what are the legal options open to them regarding the consideration of the current contract for Thameslink; and what are their consequences, implications and forecast costs. [HL11691]

Earl Attlee: The Department for Transport's options are limited by EU procurement rules.

Continuing with our current procurement process with a view to reaching contractual close with Siemens is our preferred option and the one we are pursuing. This would enable circa 1,200 new trains to be delivered, enabling a 24 trains per hour service through the core of London by 2018, and facilitate a cascade of existing Thameslink trains to other parts of the rail network.

The utilities regulations and European law prohibit the introduction into the evaluation process at this stage of new criteria that might alter the outcome of the procurement process. This is not therefore an option open to the department.

The invitation to tender has a provision that allows the Secretary of State to terminate the competition. The wording of this right in the invitation to tender is as follows:

"The issue of this ITT in no way commits the Secretary of State to award the TRSP [Thameslink Rolling Stock Procurement] to any person or party. The Secretary of State reserves the right to terminate the competition, to award the TRSP without prior notice, to change the basis, the procedures and the timescales set out or referred to in this document, or to reject any or all Proposals and to terminate discussions with any or all Bidders at any time. Nothing in this ITT should be interpreted as a commitment by the Secretary of State to award the TRSP to a Bidder".

This power is constrained by the overarching procurement law under which the competition was conducted.

The legal framework would not allow the Secretary of State to vary the procedures or the basis of the competition in a manner that could disadvantage any bidder in a way that altered the outcome of the competition.

The Secretary of State does have a power, in certain circumstances, to terminate the competition. However, any decision to terminate would have to be based on valid and defensible reasons, for example that changes in external factors result in the overall Thameslink programme no longer being value for money or affordable to the taxpayer.

If bidders considered that the reasons for termination were not valid, they might choose to challenge the decision. If successful, they might be able to injunct the Government and prevent the termination of the current procurement. There is also a risk that bidders could be awarded damages, including loss of profit.

Even if a decision to terminate and retender on a different basis was taken based on valid reasons and survived a challenge in the courts, it would not be possible to achieve an early award of a new contract. This could take two to three years and the outcome of such a tender would be uncertain.

This would delay the much needed capacity increases associated directly with Thameslink and the cascade of vehicles to support electrification programmes in the north-west of England and on Thames Valley routes. It would also result in less efficient delivery of the infrastructure works associated with the Thameslink programme, resulting in higher delivery costs to Network Rail. Both the delay of benefits and less efficient delivery would adversely impact on the value for money of this public expenditure.

Asked by ***Lord Chidgey***

To ask Her Majesty's Government what is their assessment of the long-term cost of the Thameslink contract if it were funded by usual government borrowing procedures and at an interest rate of 3 per cent, rather than by the private finance initiative procedure, all other factors remaining the same. [HL11695]

Earl Attlee: We are unable to undertake and disclose the requested assessment of the long-term cost of the Thameslink contract at present because this would disclose the preferred bidder's capital costs of trains and depots. This information is commercially confidential and disclosure may harm the commercial interests of the bidder and the Department for Transport.

Furthermore the department is bound by the process agreement entered into between bidders and the department that prevents the disclosure of information about the bidders' proposals.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government which companies or individuals have been retained by the Department for Transport, or have invoiced that department, in relation to consultancy services for the Thameslink rolling stock project. [HL11803]

Earl Attlee: The Department for Transport has been invoiced in relation to the Thameslink rolling stock project by the companies Arup, Booz, First Capital Connect, Nichols, PricewaterhouseCoopers and Willis, as well as by the limited liability partnership Freshfields Bruckhaus Deringer.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government which companies or individuals have been retained by the Department for Transport, or have invoiced that department, in relation to consultancy services for the Intercity Express programme. [HL11804]

Earl Attlee: The Department for Transport has been invoiced in relation to the Intercity Express programme by the companies Elan IT, Mott MacDonald, Nichols, PricewaterhouseCoopers and Steer Davies Gleave, as well as by the limited liability partnership Freshfields Bruckhaus Deringer.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government whether they will place in the Library of the House a copy of the reassurances received by the Department for Transport on the information barriers in place within those consultants or consultancies used for Thameslink rolling stock; and whether they have ensured that there was no conflict of interest or impropriety where consultants were advising one or more bidders. [HL11852]

Earl Attlee: It is the Department for Transport's policy to require all consultants and advisers to declare any possible conflicts of interest when offering their services on any particular contract or assignment. This requirement is set out in the contract terms issued to consultants and advisors when invited to bid for a contract.

Furthermore, bidders are advised that it is their ongoing responsibility to advise the department of any change in circumstances that could be viewed as a conflict of interest during the period of the contract.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what discussions they have had with Siemens about the Thameslink contract since they were awarded the contract. [HL12201]

Earl Attlee: Siemens and Cross London Trains were appointed as the preferred bidder for the Thameslink rolling stock project contract on 16 June 2011. The Department for Transport and Siemens plc have been finalising the terms of the contract since then.

Social Fund

Questions

Asked by ***Baroness King of Bow***

To ask Her Majesty's Government, further to the Written Answer by Lord Freud on 11 August (*WA 436–40*), which of the 72 organisations listed as respondents to the March 2010 consultation on reform of the Social Fund supported the provision of goods and services instead of cash for community care grants. [HL12068]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): Of the 72 respondents to the March 2010 consultation on the Social Fund, 26 were against the provision of goods and services instead of cash for community care grants.

Seventeen organisations and two individuals were supportive, but 10 of these voiced reservations. The remainder of respondents gave either a neutral response, or did not comment.

The supportive organisations are listed below:

Financial Inclusion Taskforce;
Money Advice Trust;
SAY Women
A4e;
Consumer Focus;
HLG;
Stonham Floating Support;
Homeless Link;
National Association of Welfare Rights Advisers;
Family Action
Age UK;
Stockport Advice;
Home Group
Save the Children;
Personal Finance Research Centre;
Broadway; and
Yorkshire Housing.

Asked by ***Baroness King of Bow***

To ask Her Majesty's Government what was the annual average Social Fund community care grant award (a) nationally, and (b) in the central and east London area, in each year since 2000–01. [HL12069]

Lord Freud: The information available is provided below.

Community Care Grants Annual Average Initial Award (£)

Year	*Great Britain*	*Central and East London*
2000-01	338	N/A
2001-02	338	N/A
2002-03	342	N/A
2003-04	364	N/A
2004-05	390	499
2005-06	406	487
2006-07	420	491
2007-08	458	543
2008-09	442	547
2009-10	437	582
2010-11	466	630

Source: DWP Social Fund Policy, Budget and Management Information System Notes:

The average award for Central and East London cannot be provided for years prior to 2004-05 as boundary changes were made which mean that the equivalent area did not exist before 2004-05. Between 2004-05 and 2007-08 there were two areas which when added together form the current Social Fund Budget Area of Central and East London.

For community care grants the method of calculating the average awards is to divide initial gross expenditure (excluding the value of review awards) by the number of initial awards. Therefore the figures above do not include awards made on review.

The Great Britain figures are not consistent with the Secretary of State's annual report on the Social Fund for 2000-01 as the methodology for calculating average award changed in 2001-02 (revised figures for 2000-01 were published in this report) and the figures above use the new methodology (as described in the previous bullet point).

Asked by ***Baroness King of Bow***

To ask Her Majesty's Government what amount and percentage of Social Fund community care grant was awarded to (a) pensioners, (b) unemployed people, (c) disabled people, (d) lone parents, and (e) others, in each year since 2000–01. [HL12070]

Lord Freud: The information requested is provided below.

Gross Expenditure by Applicant Group for Community Care Grants in Great Britain (£ millions)

Applicant Group	*Pensioners*	*Unemployed*	*Disabled*	*Lone Parents*	*Others*
2000-01	10.4	10.3	34.4	32.4	12.4
2001-02	10.1	10.0	36.9	33.2	12.3
2002-03	10.0	11.6	39.1	35.0	12.3
2003-04	11.3	12.6	41.5	38.6	13.5
2004-05	12.8	13.7	44.4	41.6	14.6
2005-06	13.7	15.2	46.9	45.8	15.4
2006-07	13.7	15.9	47.0	47.4	15.3
2007-08	13.8	15.3	47.8	47.5	14.6
2008-09	13.4	15.8	46.8	47.2	16.0
2009-10	12.5	20.9	46.2	44.2	14.9
2010-11	11.7	24.1	42.8	42.2	18.1

Gross Expenditure by Applicant Group for Community Care Grants in Great Britain (percentage of total amount)

Applicant Group	*Pensioners*	*Unemployed*	*Disabled*	*Lone Parents*	*Others*
2000-01	10.4	10.3	34.4	32.4	12.5
2001-02	9.9	9.7	36.0	32.4	12.0
2002-03	9.3	10.8	36.2	32.4	11.4
2003-04	9.6	10.7	35.4	32.9	11.5
2004-05	10.0	10.8	34.9	32.7	11.5
2005-06	10.0	11.1	34.3	33.4	11.2
2006-07	9.8	11.4	33.7	34.0	11.0
2007-08	9.9	11.0	34.4	34.2	10.5
2008-09	9.7	11.3	33.6	33.9	11.5
2009-10	9.0	15.1	33.3	31.9	10.8
2010-11	8.4	17.4	30.8	30.4	13.0

Source: Annual reports by the Secretary of State for Work and Pensions on the Social Fund 2000-01 to 2010-11

Notes:

The tables above include awards made on review.

Figures and percentages may not sum due to rounding.

Transport: Sleep Apnoea

Questions

Asked by ***Lord Clement-Jones***

To ask Her Majesty's Government whether they plan to implement screening of large goods vehicle and passenger service vehicle drivers for sleep apnoea in the light of cases of serious injury and death caused by drivers suffering from this disorder. [HL12042]

Earl Attlee: Those who drive goods vehicles and passenger carrying vehicles are already subject to a medical examination when they apply for a driving licence at the age of 45 and every five years thereafter until 65 when an examination is required every year.

The reporting doctor must record whether there is a history of or evidence of sleep apnoea.

There are no plans to implement additional screening measures of large goods vehicle and passenger carrying vehicle drivers for sleep apnoea.

Asked by ***Lord Clement-Jones***

To ask Her Majesty's Government whether they will reconsider their position that the current arrangements for the medical screening of large goods vehicle drivers, including in relation to the control of sleep apnoea, are "adequate", as stated in the Department for Transport's November 2008 response to coroner Christopher Sumner's rule 43 report of 5 August 2008. [HL12043]

Earl Attlee: There are no plans to change the current arrangements for ensuring that those who drive large goods vehicles and passenger carrying vehicles meet the appropriate health standards.

Those who drive large goods vehicles and passenger carrying vehicles undergo a medical examination and report on application, at the age of 45 and every five years thereafter until 65 when an examination is required every year.

Since the rule 43 report from coroner Christopher Sumner, the Driver and Vehicle Licensing Agency (DVLA) has made changes to the medical report and accompanying notes to make doctors consider more carefully whether sleep apnoea may be present. The reporting doctor must record whether there is a history of or evidence of sleep apnoea.

All drivers diagnosed with sleep apnoea at any time are required by law to notify the DVLA.

Transport: Trams

Question

Asked by ***Lord Bradshaw***

To ask Her Majesty's Government whether, in the examination of the tram template for the United Kingdom in the Berry report, as well as the trams themselves, they have focused on the costs incurred in infrastructure provision for tram systems in the United Kingdom; and whether they have examined a method to reduce the costs associated with disturbance to utilities. [HL12130]

Earl Attlee: The report, *Green Light for Light Rail*, published on 20 September 2011 following a review into how to reduce costs commissioned by the Parliamentary Under-Secretary of State for Transport, Norman Baker, recommends not only consideration of standardisation of tram vehicles but a more standard and uniform core design to take advantage of lower cost specifications for all infrastructure elements associated with a light rail system.

The report also found that one of the main reasons for high construction costs for light rail systems is related to works to divert or remove utility apparatus. The department will shortly be seeking views from key parties from both the utility and light rail sector to explore in more detail the options for avoiding the diversion of utilities as well as the case for reforms where diversions do need to take place. The report highlights a number of key questions which we hope will be addressed through this work.

Universal Credit

Questions

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what is the proposed cost to individuals of using the designated telephone line to claim universal credit. [HL12028]

To ask Her Majesty's Government what assessment they have made of the cost to individuals of making an application for universal credit (a) by post, (b) by telephone, (c) online, and (d) in person. [HL12029]

To ask Her Majesty's Government what estimate they have made of the likely proportion of applications for universal credit that will be made (a) by post, (b) by telephone, (c) online, and (d) in person. [HL12032]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): It is DWP's strategy to run our businesses efficiently, digitalising services and processes wherever possible. This is what most of our customers tell us that they want and it provides better value for the taxpayer. The plans to deliver universal credit are set out in the White Paper *Universal Credit: Welfare that Works*, which is available online. This is part of the Government's overall approach to revolutionising service delivery by making digital the default option for the provision of all government services. DWP is working closely with the Government Digital Service (GDS), which will co-ordinate and oversee the work of government online.

The new universal credit will be digital by default and will be administered primarily using a modern online service to take claims, address inquiries and enable the notification of changes. The new item system will significantly streamline the current administration process and significantly improve the end-to-end claimant experience.

We recognise that there will continue to be a minority of claimants who cannot use online services in their dealings with universal credit. For those claimants we will offer alternative access routes, predominantly by phone but also face to face or by post for those who really need it.

It is too early to give detailed costings and volumes of claimant contact via (a) post, (b) telephone (c) online and (d) in person. Nevertheless, such considerations have been factored into our planning, and the delivery of universal credit in 2013 will be informed by detailed plans.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what are the official documents of which an original copy might be required to be verified in order to establish the eligibility of an applicant for universal credit. [HL12027]

To ask Her Majesty's Government whether all applicants for universal credit will have to post official documentation, such as birth certificates, to the Department for Work and Pensions for verification. [HL12030]

Lord Freud: Universal credit is expected to be introduced in October 2013, and individuals will be migrated to the universal credit over the subsequent four years. Claimants will be given the appropriate support to help them move on to universal credit, within appropriate timescales.

It is too early to be able to say with any detail which documents claimants will need to post or to be verified, but maximising service quality and efficiency is at the heart of our design for universal credit. That means we need to minimise the amount of paper that the system is dependent upon, and we are therefore working with relevant experts to identify the best options for verification in the development of universal credit.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what is the turn-around time for new applications for each of the existing benefits and tax credits that will be consolidated into the universal credit. [HL12031]

Lord Freud: Universal credit is expected to be introduced in October 2013, and individuals will be migrated to universal credit over the subsequent four years. It is too early in the system development process to detail the turn around time for new applications to universal credit.

Nevertheless, maximising service efficiency lies at the heart of our modern, multichannel business delivery proposals for universal credit. Most claimants will contact and transact with us through digital channels, claiming and managing their business with us online, supported by smaller, expert face-to-face and telephony channels offering redesigned, streamlined products and services. This more automated system will help DWP delivery universal credit more efficiently.

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government whether micro-employers, such as citizens who use direct payments to employ a carer, will access universal credit. [HL12151]

Lord Freud: Whether or not a claimant is a micro-employer is not at issue in determining eligibility for universal credit. As set out in the Welfare Reform Bill, eligibility is determined by a claimant's personal circumstances, including their financial position. In the specific case of claimants who use direct payments to employ a carer, it is not envisaged that the direct payment would be taken into account in the assessment of the claimant's income, where that payment is made to meet an additional need the claimant has.

Visas

Question

Asked by ***Lord Laird***

To ask Her Majesty's Government, further to the Written Answer by Baroness Browning on 6 July (*WA 78*), whether the figure quoted in the impact assessment by the UK Border Agency on the reform of the points-based student immigration system of a loss to the economy of £2.438 billion includes the full expected costs, benefits and impacts of those non-European Union students no longer allowed to work in the United Kingdom; and whether any feedback was provided to civil servants by the Minister responsible for the impact assessment. [HL11714]

The Minister of State, Home Office (Lord Henley): I can confirm that the impact assessment on reform of the student system was drawn up in the standard format and that therefore the net figure is based on the calculable costs, benefits and impacts to the economy, including the impact of students no longer working. The Migration Advisory Committee is currently reviewing the assumptions made about the replacement of international students who were working by non-migrant workers.

The impact assessment was approved by Ministers in the normal way.

Tuesday 11 October 2011

ALPHABETICAL INDEX TO WRITTEN STATEMENTS

Tuesday 11 October 2011

ALPHABETICAL INDEX TO WRITTEN ANSWERS

NUMERICAL INDEX TO WRITTEN ANSWERS

Volume 730
No. 202

Tuesday
11 October 2011

CONTENTS

Tuesday 11 October 2011