National Health Service reform and health care professions bill : fifth sitting, Tuesday 4 December 2001 (morning) / Standing Committee A.

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Standing Committee A

NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS BILL

Fifth Sitting

Tuesday 4 December 2001

(Morning)

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Standing Committee A

Tuesday 4 December 2001
(Morning)

[MR. ALAN HURST *in the Chair*]

NHS Reform & Health Care Professions

Clause 11

DUTY OF QUALITY

10.30 am

Dr. Evan Harris (Oxford, West and Abingdon): I beg to move amendment No. 161, in page 17, line 3, at beginning insert—

'(1) In subsection 18(1) of the 1999 Act (duty of quality), after the first word "of" there is inserted "the Department of Health,".

(2)'

The Chairman: With this it will be convenient to discuss amendment No. 160, in page 17, line 5, at end insert

'including monitoring the provisions of health and safety legislation and infection control measures'.

Dr. Harris: Amendment No. 161 is a probing amendment to discover whether the duty of quality, which is covered by the Commission for Health Improvement, extends to the working policies of the Department of Health. I hope that the Minister will reassure me and other hon. Members who are concerned about the matter.

One of the key influences on the delivery of quality in the health service is Department of Health policy. To a certain extent, the practices of the Department and its agents are already covered by the CHI. The danger is that the commission will spend its time inspecting the work of hospital trusts and primary care trusts; but those trusts merely do what the Government have asked them to do. That may be an effective ploy for the Government, because—unintentionally or otherwise, and regardless of whether the commission finds good or poor practice—its reports will let the Government and the Department off the hook. However, the subjects of those reports will be attempting merely to implement policies promulgated by the Department of Health.

In earlier debates, I mentioned the Liberal Democrats' concern that, however well-intentioned they may be, the central diktats of the Department of Health may distort clinical priorities. By that, I mean that patients may not be dealt with according to their clinical needs, and that the work of doctors and nurses will be based upon the need to fulfil political targets set by the Department. I do not say that the Government invented that approach, but they have perfected it. We need not only a truly independent commission, but a definition of quality, which the Government should welcome, that allows the commission to take a circumspect look at whether the duties imposed by the Department on trusts and staff are in the interests of patients.

I welcome the Government's commitment to quality. We have always supported the setting up of the Commission for Health Improvement, and we welcome the initiative in the Bill to make the commission more independent. What better way could there be to show such commitment than the Government having the courage to allow the commission to inspect the work and policies of the Department of Health?

I accept that amendment No. 161 is not sufficient to add the Department of Health to the relevant parts of the Bill or of the Health Act 1999, which sets up the commission. I hope, however, that the Minister will reassure me that the Department's policies are already subject to independent expert overview through the Commission for Health Improvement, or in some other way.

The clauses that relate to the commission make it more effective. However, the more effective we make the commission, the more important it is that it should examine the policies of the Department, whoever controls it. The commission might decide that those policies, and the priorities that they place on the service, are good. The Government could publicise and benefit from such a judgment. However, many people in the health service whose work runs the risk of being deemed to be inadequate feel their political masters should run the same risk. Given the way in which the Government run the health service, they are, indeed, both political and masters.

I agree with those in the health service who feel that the quality agenda must be dealt with. There are problems with the delivery of quality, although we accept that they are not all due to under-resourcing and undercapacity. The publication this morning of the latest report by the national confidential inquiry into perioperative deaths puts the issue in similar terms. However, much of the failure to deliver quality is due to the lack of resources. Corners are cut because there are no funds for the staff, equipment, theatre lists, expert opinions and diagnostic techniques that would deliver the highest-quality service.

No local hospital or primary care trust can magic up extra resources; that is the responsibility of the House. It is also the direct managerial responsibility of the Secretary of State for Health, although it would perhaps be more appropriate to say the Chancellor of the Exchequer. Nevertheless, such matters are dealt with through Department of Health policies, allocations and prioritisations. The service is short of cash, and quality suffers as a result. In those circumstances, it would be invidious for the Department's funding and priority policies not even to be inspected. It is not a question of the Department getting off scot-free; indeed, the commission's diagnosis might be that there is no case to answer.

The Health Act 1999 does not lend itself to simple amendments that would include the Department, but it lends itself to some amendments. I accept that amendment No. 161 is not extensive enough to place a

[Dr. Harris]

supervisory duty on the commission. However, a way could be found. If the Minister does not reassure me, we might have to return to the issue later. I hope that we can ensure that the commission examines the provision of health care and the quality of the commissioning of health care against the quality standard that, rightly, has been established. If that is not already in the remit, it is an omission.

The commission should be able to examine the quality of performance of those who direct the commissioning and provision of health care. If nothing else, that describes what the Department does. It directs providers and commissioners through national service frameworks and the National Institute for Clinical Excellence; the body that it hides behind when rationing decisions are made. There is a huge incentive for hospitals, providers and commissioners to comply when their political masters tell them that they will be awarded no stars in some simplistic mumbo-jumbo star rating performance system, or that jobs will be on the line. They scarcely have time to consider whether that is in patients' interests, because they are faced with must-dos.

The Government could deal with the problem by not producing so much centralised guidance. I think that that would be difficult for any Government. An alternative would be for the Department to allow the same standards of inspection of its own policies as it imposes on the rest of the service in both its provider and commissioning status. I hope that the Minister will say that this provision is unnecessary, inappropriate or otherwise covered.

Amendment No. 160 seeks to probe further the extent of the expansion of the definition of the duty of quality in the Bill. In Section 18 (4) of the Health Act 1999, "health care" is defined as:

"services for or in connection with the prevention, diagnosis or treatment of illness".

Clause 11 will add to that definition,

"and the environment in which such services are provided".

The amendment seeks to add to that definition the implementation of

"health and safety legislation and infection control measures",

although I accept that its current wording does not quite achieve that effect. The British Medical Association is particularly concerned that not enough priority is given to those areas by hospital managers and the health service when attempting to deliver the duty of quality.

The cost of poor infection control to the health service, set out by the National Audit Office less than two years ago, is high. It would be of great concern if the health service were not inspected on that quality. The BMA briefing states:

"despite existing legislation and guidance, health and safety is still not universally guaranteed throughout the NHS. The NHS has a responsibility under the Health and Safety at Work etc. Act, 1974, and subsequent regulations on the management of health and safety to ensure the safety of all employees, contractors and members of the public as patients and visitors. Each NHS Trust and Primary Care Trust has a statutory duty to provide an environment that is safe 'as far as is reasonably practicable', to use 'the best practical means' to achieve its objectives, and to use 'the best available technology not entailing excessive cost'.

The Commission for Health Improvement, as part of its inspection process"—

including the new inspection powers in the Bill—

"is in a prime position to observe whether premises, equipment, practices and procedures in each trust are sufficient to enable best clinical practice."

The amendment is also tabled in the name of the hon. Member for Wyre Forest (Dr. Taylor), who may wish to speak about the importance of dealing with cross-infection. The NAO report to which I referred recognised the widespread failure in infection control. It seems reasonable that the Bill should be amended to ensure that that function is covered by the Commission for Health Improvement, or that the Minister should reassure us that infection control and health and safety at work are already covered by it.

The NHS staff is its major resource, on which the majority of its funds are spent. The way in which the NHS treats its staff is a measure of the quality of the service. Concern has been expressed that the occupational health facility is poor, if it exists at all. As a result, trade unions and professional organisations run heavily subscribed helplines and stress counselling lines, which should be provided within the health service by the employer; particularly an employer which puts its workers under such strain. The personnel function must not be overlooked in the workings of the NHS; the key to undercapacity lies not only in the failure of resourcing over so many years, but in the failure to retain staff, many of whom are leaving because of the stresses and strains of the workplace.

If occupational health policies were more effective, we might be able to improve NHS delivery and maintain and increase the service's capacity, which is the critical issue facing it. If the definition of quality were extended to include the quality of the human resource function, or the Minister were to reassure us that certain guidance clearly so extends it, the Committee would be reassured and the amendment could be withdrawn. I commend the amendments to the Committee.

10.45 pm

Dr. Richard Taylor (Wyre Forest): My name is attached to amendment No. 160, but I support amendment No. 161, which was tabled by the hon. Member for Oxford, West and Abingdon (Dr. Harris). However, I am primarily interested in amendment No. 160. I thoroughly approve of the vagueness of the wording in clause 11, when it refers to

"the environment in which services are provided."

I presume that "environment" is meant to be vague, because it includes all hospitals, practices, clinics and facilities where health care is provided. I approve of that. The amendment attempts to make more specific some of the Commission for Health Improvement's functions. As has been said, we are interested in the health and safety issues, especially cross-infection. I remind the Committee of the recent seminar held by the Patients Association, which pointed out the

tremendous risk of the transmission of very serious infections through the re-use of surgical equipment. Policies in units that have allowed that to happen are somewhat lax. It is crucial that the CHI is able to inspect for that sort of thing. The amendment is designed to add teeth to the clause, so that cross-infection is inspected meticulously during CHI inspections.

Mr. Simon Burns (West Chelmsford): As the hon. Member for Wyre Forest said, the clause is vague in its definition of the environment in which such services are provided. The hon. Gentleman welcomed that vagueness because he thought that it would make the clause all-embracing in its interpretation. I have a lot of sympathy with his point. However, as hon. Members who have received the BMA briefing on the amendment will know, at this stage in the consideration of the Bill such vagueness must be explained further to reassure Members that the provision will enhance the inspection process and the standards to be imposed on our hospitals and patient care, rather than being so vague that nobody knows what it means and it achieves nothing. I suspect that the latter analysis is inaccurate and that the Minister will reassure us that such vagueness will enhance the process. As the BMA rightly said, the amendment is probing. We want to find out how the Minister and the Department envisage matters.

As the hon. Members for Oxford, West and Abingdon and for Wyre Forest pointed out, it is important that we monitor what goes on in our hospitals more closely and more effectively, and that we improve the quality of health care. We all rightly recognise that the quality of health care is not simply confined to the quality of patient care that individuals receive, however important that is. It also includes a whole host of other issues, such as cleanliness and the administration and bureaucracy involved in running hospitals.

Hon. Members have mentioned the responsibilities of the NHS under the Health and Safety at Work, etc. Act 1974. I was especially interested in the fact that the BMA said in its briefing, from which the hon. Member for Oxford, West and Abingdon has quoted, that the NHS had a responsibility to ensure the safety of all employees, contractors and members of the public as patients and visitors. The BMA has also said that each NHS trust and primary care trust had a statutory duty to provide an environment that was safe so far as was reasonably practicable, and to use the best practical means to achieve its objectives.

Such issues are especially important in an area such as mine. There was a desperately unfortunate tragedy at Broomfield hospital in my constituency in the summer, when a blockage in an oxygen tube resulted in the death of an 11-year-old boy who went into hospital simply because he had injured his finger in the spokes of his bicycle. Due to his age, the clinical decision was that he needed a general anaesthetic before the damaged finger could be repaired, and that had tragic consequences. In the light of that tragedy—and others, fortunately not as serious, that regularly occur in the health service—one needs the best monitoring and checking of standards.

It is equally crucial that we use all means available to ensure that our hospitals are as clean as possible. The number of patients who become infected as a result of the conditions in hospital is a serious problem. The National Audit Office recently identified the fact that, as a result of failures of cleanliness in the NHS, around one in 11 hospital patients at any time has an infection caught in hospital. That is apparently equivalent to at least 100,000 infections a year. The old, the young and those who undergo invasive procedures are the most vulnerable.

Most people would find it incredible that, when they go into hospital to be treated for and hopefully cured of the medical condition from which they suffer, they might pick up an infection that compounds the problem and proves fatal in some cases. In my youth, we were brought up to think that hospitals were not only warm but spotlessly clean. It is sad that those standards have not been maintained in recent years. The problem is serious. The amendment would strengthen the powers of inspection and the duties placed on bodies within the NHS to seek to improve and enhance standards and quality of care. In some areas, those standards have deteriorated so much that they are a serious scandal.

Dr. Harris: With the narrowness of the Government's extension of the definition of health care, focusing on the environment in which services are provided might mean that a hospital is found liable for failures if that environment is grubby. I recently asked a parliamentary question that revealed that the cost of repair and maintenance backlogs throughout health authorities and hospitals in England and Wales was £52 billion. Even the best manager will not be able to conjure up that sort of funding to ensure that the environment in which services are provided look adequate, let alone function adequately.

Mr. Burns: The hon. Gentleman makes an interesting and important point. Without getting sidetracked, I must say that it will be interesting to hear the Minister's reply, given the views and concerns that have been expressed. I hope that the Minister will be able to reassure us that amendment No. 160 is unnecessary because enough provisions exist in existing legislation and in the Bill to overcome the concerns and fears that hon. Members have expressed. If that were so, I would be delighted.

Similarly, I hope that the Minister will give a better explanation of what he and the parliamentary draftsmen mean by "environment" in the context of the clause. I hope that, however vague the wording may seem to us non-lawyers, it is suitably widespread and all-embracing to fulfil the functions that we hope for from the clause.

Dr. Andrew Murrison (Westbury): National health service hospitals are potentially very hazardous places; indeed, that is true of all hospitals and medical facilities. My hon. Friend the Member for West Chelmsford (Mr. Burns) referred to the cosy image of

[Dr. Andrew Murrison]

health services, but by and large the environment is not sparklingly clean, and violence is often visited on health practitioners. There are also biohazards, and we have recently heard a lot about prions in relation to surgical instruments. Radiation hazards are also a problem for patients and practitioners, and we have heard about the problem of violence in accident and emergency departments. In short, hospitals are hazardous places.

We know that the Health and Safety Executive is under-resourced and overstretched, and although it attempts to exert its inspection function, it is not equipped for a specialised task that needs independent and expert overseeing. The Patients Association report that was published last month, and to which the hon. Member for Wyre Forest referred, is the most telling document that I have seen in relation to those matters. We should give some attention to the report, which is a compilation of reports from a variety of authorities, including the Infection Control Nurses Association, the Institute of Sterile Services Management and the National Association of Theatre Nurses. The report takes the form of a survey of 300 members of those associations.

The survey stated:

"Almost a third of respondents . . . said that they did not think that the CE mark guaranteed instrument sterility."

That is a serious finding. The report also stated that

"one-fifth of respondents do not currently have an infection control policy in place relating to decontamination issues."

That is extremely worrying.

"Only just over half of respondents (56 per cent.) said that their hospital had a single-use policy committee in place, despite this being a suggestion from the Department of Health."

The survey is worrying, and the Bill presents a good opportunity for the Government to embed health and safety and infection control, which are both aspects of quality, in the national health service in a way that is not happening at present.

11 am

To return to my original premise, we need to start thinking of hospitals as hazardous places. The Health and Safety Executive is used to dealing largely with factories. The industry that we are considering is, one might say, a factory with a multitude of fairly unregulated processes. It is not a production line and cannot be well regulated. Many unexpected events are built in to the activities of clinicians in hospitals; that makes things hazardous. That is why we need to attend particularly to health and safety and, of course, infection control.

I support the amendment, and particularly the attempt to embed health and safety and infection control in the national health service at this seminal time of change.

Dr. Taylor: I am grateful for a second bite of the cherry, Mr. Hurst. I shall be brief.

The Royal College of Nursing has raised several issues about quality that have not been mentioned yet, the first of which is nutrition. There have been reports recently, sadly, of elderly patients not receiving the correct food, or enough of it, in hospitals. Secondly, privacy and dignity are always matters of concern. Any hon. Members who have been in hospital recently may have been asked whether they would like to be called by their Christian name or a title. I have spoken to elderly ladies who have been greatly bothered when junior nurses called them by their Christian names. That is a small matter, but it is a matter of dignity, which comes under the heading of quality.

The Minister of State, Department of Health (Mr. John Hutton): This has been a good debate, and I take it to have been a constructive attempt to get to the bottom of the provisions. It may help if I explain the intention of clause 11, as I think that there was some confusion about it on the part of the hon. Member for Oxford, West and Abingdon.

In simple terms, clause 11 is intended to widen the definition of health care in section 18 of the Health Act 1999 to include, in broad terms, the patient environment. The clause supports the expanding role that we envisage for the Commission for Health Improvement. If the Bill becomes law, the commission will be able to examine the wider patient environment.

Several hon. Members spoke about what is meant, for our purposes, by the word "environment". It is important that discussion of the quality of care given by hospitals—NHS providers and others—should not be confined to issues of clinical care. As the hon. Member for Wyre Forest pointed out, with practical emphasis, quality goes much wider and deeper than that. We simply want to allow the commission to conduct a wider range of inspections based on the expanded definition of the duty of quality.

We envisage "environment" covering, for the purpose of the clause—I am not giving an exhaustive list, but suggesting our thinking—the cleanliness of hospital wards, which would clearly not be covered by the current definition of health care; the cleanliness of waiting areas and other parts of the hospital; and the quality of the food given to patients. The hon. Member for Wyre Forest noted the importance of food, in his remarks about nutrition. Many aspects of the environment in which NHS care is given are relevant. The clause would establish a broader view of quality.

The hon. Member for Oxford, West and Abingdon wanted to know whether the Commission for Health Improvement would be able to consider the quality of commissioning. It can already do that. The commission can certainly examine the quality of commissioning by NHS bodies in reviewing arrangements for improving and monitoring the quality of NHS care under section 20(1)(b) of the Health Act 1999.

Hon. Members made important points about cross-infection and the importance of maintaining a safe, sterile environment in hospitals.

Dr. Harris: Will the Minister repeat his reference to the Health Act 1999?

Mr. Hutton: I referred to section 20(1)(b).

The issue of cross-infection is important. I am sure that hon. Members will be conscious of the action that we have taken to bring about improvements in that respect. That includes issuing, in November 1999, national standards for hospital-acquired infection. Those standards are being reviewed by the Department, with the help of interested professional groups. I know that the chief medical officer is working on those issues. The Department of Health commissioned evidence-based guidelines for preventing hospital infection and those were published in January as a supplement to the Journal of Hospital Infection. The guidelines cover general principles for preventing infection in hospital, and for the prevention of infections associated with specific clinical procedures.

Hon. Members may know that all acute NHS trusts must, as of April this year, participate in the national surveillance of hospital-acquired infection. Data from that exercise will be available from April next year. That is the first stage in developing a comprehensive NHS surveillance service. One of the problems has been the lack of consistent definitions and data about methicillin-resistant staphylococcus aureus and other acquired infections. We are obviously anxious to ensure that the necessary information is obtained to allow us to make progress.

Dr. Harris: When the Minister referred to section 20(1)(b), I thought that he meant section 21(b). Section 20(1)(b) refers to

"the function of conducting reviews of, and making reports on, arrangements by Primary Care Trusts or NHS trusts for the purpose of monitoring and improving the quality of health care for which they have responsibility".

No specific mention is made of commissioning or, indeed, the Department of Health policies on which those commissioning policies must be based.

Mr. Hutton: The commission is able, under section 20(1)(b) to examine the quality of the commissioning process. We are in no doubt about that, and neither is the commission. It is perfectly proper for the commission to focus on that, if it chooses.

We need to focus our concern on the amendment, and I hope that what I have said about health and safety legislation and infection control measures—with which the hon. Gentleman's amendment No. 160 deals—makes matters clear. We consider that section 18 of the Health Act 1999, once amended under the Bill, would enable those issues to be taken fully into account. NHS bodies are already required to comply with health and safety legislation, and the service is obliged to follow extensive departmental guidance on infection control measures; a matter that the Commission for Health Improvement can pursue. In view of all that, the amendment would have no practical consequence, as it would provide for exactly what is happening.

The hon. Member for Oxford, West and Abingdon raised an important issue that is not covered by the amendment, although he suggested that he might want to return to it later; perhaps on Report. He said that the Commission for Health Improvement should have a duty to inspect the quality of decisions made in the Department of Health in the process of forming policy. We must be clear; that is our job. It should not be given to someone else. It is the role of Parliament and the job of Members in this place to hold Ministers to account for their decisions.

The hon. Gentleman raises a fair point about there being one standard for Ministers and one for the NHS, but he is confusing two separate issues. Ministers must be properly accountable to this place for the quality not only of their decisions, but of the care available to our constituents. In turn, we have a responsibility to put in place a range of measures designed specifically to improve quality of care. That is why we now have arrangements to set national standards through the national service framework. It is why we have the Commission for Health Improvement—it has been given an expanded role in the Bill to go into every corner of the NHS and consider the quality of care and the patient environment—and the National Institute for Clinical Excellence, which provides clear guidance to the service about the availability of new drugs and treatments.

Such arrangements are precisely the right ones for Ministers to put in place. Ultimately, the accountability for decisions is inappropriate for the commission. It should rest with Members of Parliament in this place.

Dr. Harris: I am grateful to the Minister for the considered and thoughtful way in which he is responding, and I accept his point, to an extent. However, I shall give an example of my concern about Department of Health guidance. If the CHI has the power to consider commissioning policies that might be based on a direction from the Department that says, "Thou shalt commission to ensure maximum waiting times that shall not be exceeded," can it take a view on whether that is a sensible, quality-based, patient-centred approach?

Mr. Hutton: In a sense, some of the hon. Gentleman's concerns may be the subject of a fuller debate on clause 14, which entrusts to the commission the responsibility for publishing an annual report on the state of the NHS.

The hon. Gentleman made a point about the role of the commission, which clearly will comment on the quality of patient care, in the widest sense of that definition. Through these measures, the commission is being given greater independence from the Department, an important step that contradicts the hon. Gentleman's obsessive theory about micro-management of the NHS. The debate has been full, and we have been over the course on this issue many times.

We should return to clause 11 or we will find ourselves in some trouble. It provides an important extension of the duty of quality, which I accept has the deliberate intention of expanding the remit of the commission to the consideration of patient quality. That has to be good for our constituents. We all know that we are as likely to hear complaints about hospital

[Mr. Hutton]

food, cleanliness, general tidiness and civility—the hon. Member for Wyre Forest mentioned the last of those—as we are complaints about the quality of care.

If we start from the proposition that the commission is the right repository of the relevant functions, the right set of structures are in place to drive up the quality of care in the NHS, given that the commission is at arm's length from the Government, has the fullest remit that we can construct for it and is consistent with established lines of accountability, under which Ministers and their decisions are accountable to the House.

Dr. Harris: I congratulate the Government on making the Commission for Health Improvement more independent, and for recognising that that was the correct conclusion for the Kennedy report to recommend. However, I want to return to my specific point. Under the Bill or the existing powers, will the commission have the ability to judge whether the commissioning of services to provide maximum waiting times as an end-point is good for quality of care? Will it be able to comment on such policies? That is an example; I would not want to appear obsessed.

Mr. Hutton: We have to consider the subject in a slightly broader context. Inspection of the national health service is not a role only for the Commission for Health Improvement. For example, value-for-money issues are the remit of the Audit Commission, and I know only too well that that commission's writ runs freely across the value-for-money agenda of the NHS. Indeed, the commission has done so recently in relation to the issues raised by the hon. Gentleman, such as clinical priorities and setting reasonable targets to reduce waiting.

I, my colleagues in the Government and, I hope, my hon. Friends believe that our constituents' most important concern about the NHS is the length of time that they have to wait. We are travelling in absolutely the right general direction to so organise the services provided and funded by the NHS that we can reduce that time. I believe that it is possible to do that without distorting clinical priorities. We make it clear in guidance to the service that care should ultimately be determined according to clinical priority; indeed, that is the first sentence of the guidance. It is not the job of Ministers, nor should it ever be, to decide which patients are treated first, or last. That is the job of clinicians, as we have always tried to spell out.

11.15 pm

Mr. Burns: The Minister is being a little naïve in coming out with that pious point. He knows as well as anyone that under the discredited waiting list initiative of the previous Parliament, clinicians and hospital managers were under such pressure to meet the politically motivated number deadlines that clinical decisions were grossly distorted. That was done to ensure that Ministers, including the Prime Minister, were not embarrassed by a failure to meet promised targets.

Mr. Hutton: The hon. Gentleman will not be surprised that I disagree with every word of what he said. He is wrong. It does not serve the quality of our debate for the hon. Gentleman to pretend that his Government were not interested in doing the same. We should not forget that the Conservative party set the original maximum waiting time of 18 months for treatment in the national health service in England. He cannot now pretend that his Government were not fundamentally concerned with that matter.

Mr. Burns: We were talking about times, not about numbers.

Mr. Hutton: The hon. Gentleman must follow the logic of that conclusion. I know the view of the hon. Member for Oxford, West and Abingdon, which could also be the view of the hon. Gentleman; we may yet find out. Perhaps the hon. Member for Oxford, West and Abingdon believes that even setting a maximum waiting time could distort clinical priority.—[*Interruption.*] That is his view. I wonder if that might be the view of the hon. Member for West Chelmsford, whose party set the original waiting times target.

Mr. Burns: The initiative of the last Parliament, which was based on numbers, distorted clinical priorities. However, I have sympathy with the Minister when he says that all of us—apart from the Liberal Democrats, it would seem—want people to wait less. I believe that having maximum times and then reducing them will improve and enhance health care for our constituents.

The Chairman: Order. I am sure that hon. Members will be mindful not to stray too far from the amendment.

Mr. Hutton: I must apologise, Mr. Hurst; I lured the hon. Gentleman into that. I generally give way when it suits me, and he does the same. I have given way when it did not suit me, and I have had to bear the consequences. However, we all make mistakes.

The amendments are unnecessary because they would have no practical consequence. I have explained that the issues are already subject to inspection and review. The amendments have served the purpose of winkling out a wider sense of what we mean by "the environment". I have tried to give practical examples of what that might mean, but it would have been a mistake to attempt to produce an exhaustive list.

The hon. Member for Wyre Forest was right that we need some laxity in the definition. That suits our purpose. However, we want also to broaden the concept of health care under section 18 of the 1999 Act—that is obvious from the Bill—so that the Commission for Health Improvement, in its inspection and monitoring role, can look at the issues, which are important to patients. I have tried to respond positively to the hon. Gentleman's points, but I am unable to accept his amendments.

Dr. Harris: I am grateful that the Minister gave some response to amendment No. 160, which relates to the quality of the environment. I am disappointed that he did not address human resources policies, which I

included in my introduction. The quality of such policies impacts indirectly—and directly—on patient care. I am not clear whether the Commission for Health Improvement has a remit to consider the quality of human resources policies and occupational health within the NHS. Will the Minister respond?

Mr. Hutton: I am sorry. I assumed that the hon. Gentleman knew that the Commission for Health Improvement already has that responsibility and can look at those issues.

Dr. Harris: I am grateful. Perhaps I shall be able to see whether it does so in due course. I have spoken informally to the hon. Member for Wyre Forest and we would be happy to withdraw amendment No. 160.

The hon. Member for Wyre Forest expressed some sympathy towards amendment No. 161, which is tabled in my name. I am not convinced that the Government have addressed the issue. I am conscious that we should not stray too far from the amendment. The fundamental test posed by the amendment is whether the Commission for Health Improvement—which is the quality body, as opposed to the value-for-money body, which is the Audit Commission—has the ability to look at the impact on the quality of health care of policies that commissioners and providers are directed to follow by the Department of Health.

The decisions of Ministers should be accountable to this place in so far as they impact or might impact on the quality of health care. The expert body charged with investigations and reviews on quality should be entitled to give a view. In holding Ministers to account, the House should be entitled to reports and reviews from expert groups looking at those issues.

The Minister says that we have charged that a Department of Health policy of maximum waiting times distorts clinical priorities. That dismisses the distortion of clinical priorities that are not concerned with quality. The policy has a huge impact on quality if the most clinically urgent patients have to wait for more managerially, politically, directionally or policy-driven urgent patients, who may be less clinically urgent, who are subject to maximum waiting times. That is why our party has changed its view on maximum waiting times; we regret that the Labour and Conservative parties have not done so.

If the Minister will not give us a clear indication that the Commission for Health Improvement can look at those broad policy directions and the directions to commissioners and providers from the Department of Health, we will certainly have to revisit this issue. I accept that the phrasing of the amendment does not raise that issue, but amendments can be tabled that would clearly place that power with the Commission for Health Improvement. Today we have heard the Government say, "No, the Commission for Health Improvement does not have the power to criticise what we do where it impacts on the quality of care and the functions of primary care trusts and NHS trusts, which are going to be inspected by the commission; nor do the Government want it to." That is a failure in terms of quality.

The terms of the Kennedy report were clear; for example, waiting list policies in the early 1990s were partly responsible for the problems at Bristol; they were ultimately problems of quality. The failure to follow the spirit of the Kennedy report is that the Commission for Health Improvement will have no remit even to look at the Department of Health's policy, rather than at its decisions per se.

Mr. Hutton: The hon. Gentleman prayed the Kennedy report in aid, but Professor Kennedy did not make those particular recommendations.

Dr. Harris: I read the Kennedy report with great interest. It cited the waiting list policies—the professor described them as policies "of 10 years ago", but they are still with us—as a cause of quality failures. The waiting times target is just one example of Government policy; I do not want the debate to be solely about that. However, when waiting times are decreasing, more and more patients will be considered urgent in terms of waiting list management and will be able to jump the queue at the expense of clinically urgent patients. Kennedy was clear about the need for expert quality checks. Hon. Members may think that they are experts, but they are not always in command of the detail. Expert quality checks on the possible detrimental impact of Government policy on the quality of provision, whether it is intentional or unintentional, are necessary.

Mr. Hutton: I agree with the hon. Gentleman's comments on Professor Kennedy's report. Professor Kennedy welcomed the Government's measures for improving quality. However, the report, which the hon. Gentleman cited in aid of his arguments, did not recommend giving to the Commission for Health Improvement the power that the hon. Gentleman says it should have.

Dr. Harris: Professor Kennedy did not recommend against giving the Commission for Health Improvement the power that I recommend, either. [HON. MEMBERS: Oh!] It is true that the professor did not specifically recommend that the commission should be given such a power. However, I am sure that we could enter into an interesting correspondence with the professor and his colleagues about whether they think that the Government should have carte blanche to implement policies that may run counter to the patient's best interests, simply because the policies conform to those of the politician. That would apply whichever party was in government, and it is an important power.

I do not intend to divide the Committee on the amendment, but I hope that, after consulting outside bodies, we will be able to return to the matter later. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause stand part of the Bill.

Mr. Burns: I do not want to detain the Committee for long, but I have an important point to raise with the Minister. The clause is about enhancing the quality of

[Mr. Burns]

care and the definition of the duty of care. I was reassured by the Minister, who seemed to suggest that the vagueness of the term "environment" was for the common good. I should be interested to hear the Minister's comments on the points raised by the Royal National Institute for the Blind about the care and treatment of blind and partially sighted people in the NHS. As the Minister will be aware, there is great concern among the blind and partially sighted that the health service fails to understand their predicament and introduce the appropriate measures to help them.

Surveys have revealed the extent of the failure of most trusts and health authorities to provide information accessible to blind and partially sighted people and other people with disabilities. The RNIB's recent survey shows that only 4 per cent. of test results are made available in large print. Only 2 per cent. of test results are provided in Braille or by tape. Information about treatments and medical conditions is made available in alternative formats by fewer than half of NHS trusts. Some 86 per cent. of blind and partially sighted patients in eye clinics receive appointment letters in normal-sized print—a format that most find difficult, or even impossible, to read. It would not take much to tackle those sensitive issues, and I hope that the clause will lead to an improvement if and when the Bill becomes law.

11.30 am

The absence from many eye hospitals of trained workers to provide those facing a diagnosis of sight loss with emotional support and information is also of huge concern to the RNIB and its members. We are all fortunate enough to understand that sight is the sense that the vast majority of people most fear losing. When individuals confront that unfortunate possibility, they experience considerable fear, stress and distress. It is important that staff who provide health care have the means to help people through an especially difficult and emotional time. Practice should reflect that in other sectors of the health care system, which deal with highly distressing and emotional conditions by providing back-up support when patients are diagnosed and throughout their treatment.

All too often, those who suffer from conditions such as blindness and partial sightedness are forgotten. Sighted people tend to take it for granted that everyone is like them and to push the concerns of others to the back of the queue, as shown by the experiences in the surveys that I cited. I hope that the clause and the activities of the Commission for Health Improvement will help not only blind and partially sighted patients but patients in other forgotten areas of the health service, where fit and able-bodied individuals in the medical profession and outside it tend to forget the needs of others.

Mr. Hutton: I do not intend to go into further detail about clause 11. I hope that I spelled out the issues a few minutes ago. The hon. Gentleman raised the important issue of access to and around NHS sites for people with a disability. He gave the example of people who are blind. I strongly agree with his sentiments.

Given the extension of the definition of health care to the patient environment, the issues that the hon. Gentleman raised will fall well and truly within what we are trying to achieve. Issues such as providing signage sites and ensuring that blind and other disabled people have proper information to help them to get around sites fall four-square within the definition of the patient environment that we seek to add to clause 18. The hon. Gentleman made a fair point, and the commission will want to consider it.

Question put and agreed to.

Clause 11 ordered to stand part of the Bill.

Clause 12

FURTHER FUNCTIONS OF THE COMMISSION FOR HEALTH IMPROVEMENT

Mr. Burns: I beg to move amendment No. 155, in page 17, line 29, at end insert—

'(3A) In subsection (2), at the end of paragraph (b) there is inserted "including co-ordinating visits to Primary Care Trusts or to NHS Trusts with other bodies carrying out monitoring or inspections of those premises".

The Chairman: With this we may discuss amendment No. 162, in page 17, line 30, after '(2),', insert

'paragraphs (a) and (b) are omitted, and'.

Mr. Burns: The amendment is in my name and those of my hon. Friends the Members for Woodspring (Dr. Fox) and for North-East Hertfordshire (Mr. Heald). I make no bones about the fact that the British Medical Association recommended it to us. In many ways, it is a probing amendment. As the Minister is aware, the British Medical Association supported the establishment of CHI in 1999, and has not wavered in its support. As was said when we debated the previous clause, the main function was to consider the question of duty of care and enhance the quality of care, and a function of CHI is to monitor the quality of care provided in the health service to ensure that it meets the highest standards.

I hope that the Minister can reassure us on the danger that may result from the fact that several different bodies have responsibility for visiting, inspecting and monitoring the services and quality of care provided by NHS trusts and GPs' surgeries. Those bodies include CHI itself, the medical royal colleges and the Audit Commission. If the relevant clauses remain in the Bill and the Bill becomes law, patients forums may also carry out inquiries into areas of health care at all levels. Most visits that those bodies make will be appropriate to the fulfilment of their functions, but there is a danger that without co-ordination, visits from and inspections by the various organisations and bodies will cause disruption to trusts and GPs' surgeries. The amendment would ensure that co-ordination. I am sure that the Government do not intend such disruption to be the

by-product of their changes, which should improve and enhance patient care and the performance of the health service.

The Minister is probably aware that when Ofsted plans to visit a school, it gives the school advanced warning. Teachers, parents and pupils in all schools—I say "all schools" because I cannot believe that the school of which I am a governor in Chelmsford is an exception—give a great deal of time and effort to ensure that they are ready for a visit. That causes some disruption and a distortion of effort and energy that would otherwise be given to the education of young people. One can imagine something similar happening in the health service. A trust or a GP's surgery, in which employees are less familiar with visits from people who inspect their activities, will make preparations in time for the visit. That will involve extra effort when GPs and their staff already feel overburdened with bureaucracy and rising patient expectations, and may distort and even diminish patient care in some circumstances.

Therefore, without seeking to undermine the functions and duties of the bodies and organisations that carry out inspections or visits, there is a logic to seeking to co-ordinate the activities of those bodies to avoid placing an undue burden on trusts or GPs' surgeries. Will the Minister consider that point? I shall be interested to hear whether he shares the BMA's concern or regards it as an unfounded worry and thinks that, in practice, everything will be fine.

Dr. Harris: I have nothing to add to the hon. Gentleman's remarks on amendment No. 155, but I should like to speak to amendment No. 162. That amendment would insert a provision that section 20(2)(a) and (b) of the Health Act 1999 be deleted. Those paragraphs specifically state:

"The Secretary of State may by regulations make provision—

(a) as to the times at which, the cases in which, the manner in which, the persons in relation to which or the matters with respect to which any functions of the Commission are to be exercised,

(b) as to the matters to be considered or taken into account in connection with the exercise of any functions of the Commission".

I was concerned about those paragraphs when the 1999 Act was passed and I imagined, when the Government said that they would make CHI more independent, that they would be deleted. They give the Secretary of State power to restrict the ability of CHI to talk to the people to whom it needs to talk, to make investigations and reviews when it wants, and to consider cases as it wants. I can think of no issue governing the making of reviews and investigations that is not covered by paragraphs (a) and (b). To persuade me that the amendment is unnecessary, the Minister must justify those paragraphs, give examples of when the Secretary of State might make those provisions by regulations, and demonstrate that in doing so he does not threaten the remit, independence, scope and ability of CHI to make such investigations.

The paragraphs that I would delete are different in nature from paragraphs (c), (d), (e) and (f). Paragraph (c) dictates to whom the "advice, information or reports" are given, while (d) covers

"the publication of reports and summaries of reports",

which is subject to a welcome amendment in the Bill. Paragraph (e) relates to charges made to the accused for an investigation made into them and (f) to

"the exercise of functions . . . in conjunction with the exercise of statutory functions of other persons."

That paragraph may relate to some issues raised by the hon. Member for West Chelmsford.

The worry is that the Secretary of State may find it convenient to make provision that the Commission for Health Improvement should not consider aspects that it might want to consider in the interests of ensuring that adequate inspection is made of the quality function. For example, if CHI considered the potential risk of the transmission of new-variant Creutzfeldt-Jacob disease from surgical instruments, it might like to look at a report that the Government wanted to suppress. Indeed, a recent "Panorama" programme showed that the Government might be keen and willing to suppress such reports. It also alluded to issues in my previous amendment, but I will not cover that argument again.

Paragraphs (a) and (b) seem to give the Secretary of State the power to restrict the commission's ability to examine departmental policies, guidance to the service, executive letters and health service circulars. The Minister will have to provide clear reasons, with examples, of why such wide-ranging powers must be retained. If the Government were serious about ensuring that the commission was truly independent and had wide-ranging powers, they would think seriously about removing paragraphs (a) and (b).

11.45 am

Dr. Murrison: I wish to return to the BMA's reasoned comments on the clause. Its position on the clauses that we have discussed so far has been extremely thoughtful and generally supportive. However, the BMA is concerned about the provisions in clause 12 for multiple inspections.

From my experience as an inspector and inspectee, I know that inspections are hugely disruptive and take one's eye off the ball when it comes to what the job is all about; treating patients. The BMA draws a nice analogy between inspectors in the health sector and the men who dig up the road. An effort is being made to ensure that gas men, electricity men and plumbers dig up the road at the same time. That is because nothing is more irritating than having one's road dug up by one lot of men one week, another lot the next week and yet another lot the week after. If we can amalgamate the regulators, there is likely to be far less disruption to health care. I am sure that we would all want that.

GPs in particular are subject to a vast panoply of regulation and inspection from their royal colleges and, potentially, patients forums. They are also subject to additional regulation and inspection because they run what are, in effect, small businesses. GPs to whom

[Dr. Murrison]

I speak in my constituency are heartily fed up with that. They are worried that inspection is, paradoxically, detracting from patient care.

I should like to return briefly to the notion of total quality.

Mr. Oliver Heald (North-East Hertfordshire): I have been present since the beginning of my hon. Friend's remarks, although I apologise for not being here earlier. As regards inspection bodies, does my hon. Friend agree that one must bear in mind other burdens on GPs? The recent BMA survey showed great unhappiness among GPs about the arrangements under which they must work, particularly the level of bureaucracy. Does he agree that the Government might be putting the last straw on the camel's back by adding numerous inspections to the burden of bureaucracy and rising patient expectations that GPs face?

Dr. Murrison: Morale in general practice is a big problem. There is a huge turnover in general practice, which is becoming an increasingly unattractive proposition for clinicians. GPs face an immediate burden of bureaucracy of the kind that hospital management would take over were they hospital clinicians.

The concern is that regulation that is unnecessary or perceived to be badly thought through will dent GPs morale even further and affect recruitment and retention in primary care at a time when the Government, rightly, are putting greater emphasis on such care. Total quality is an important notion that has been well grasped by industry and is also applicable to the health care sector. For total quality, one needs to consider all health care functions as a whole. The concern is that by splitting those functions up among various inspectorates, one will not only put a huge burden on practitioners, but reject the notion of total quality. I take issue with the Minister's remarks about health and safety being separate from health outcomes in general. I hope that he will take a more holistic view of the work of the health service.

Dr. Taylor: I would like to ask the Minister a question in relation to amendment No. 162. We believe that the Government are keen for the CHI to become increasingly independent. Is that not a reason to remove not only paragraphs (2)(a) and (b) from section 20 of the 1999 Act—as my hon. Friend the Member for Oxford, West and Abingdon suggested—but subsections (3) and (4)?

Mr. Hutton: There are two separate amendments, which propose completely opposite things. I want to return to that point shortly.

In essence, amendment No. 162, tabled by the hon. Member for Oxford, West and Abingdon, is about improving the independence of the Commission for Health Improvement. Sadly, it is my duty to point out to him that his amendments would not actually achieve that, because they leave in the original legislation the power of the Secretary of the State to give directions with respect to the exercise of any of the commission's functions. His amendments are deeply unhelpful for another reason, and I will deal with that point in a moment.

I have a great deal of sympathy with amendment No. 155, which deals with the need for proper co-ordination in relation to the inspection functions. My starting point is that we must ensure that the inspection process for the national health service adds value to the quality of patient care. I agree with the hon. Member for Westbury (Dr. Murrison) that it is not part of the Government's intention or ambition to have—as he might put it—an army of inspectors trampling across the NHS on a routine basis, 24/7, disrupting patient care. That would be ridiculous.

I take issue with the hon. Gentleman's remarks as I did with those that he made on Second Reading, when he queried the value of much inspection work. On primary care, he said that inspection was already having a negative impact on the quality of care delivered by GPs. The Commission for Health Improvement has conducted only pilot reviews of primary care groups. It intends to consider primary care trusts more widely later next year through the existing clinical governance reviews, not the wider reviews that we are discussing in relation to the Bill because the necessary provisions will not be on the statue book by then.

Primary care provides a poor example of the deleterious effect of the bureaucracy of inspection. The hon. Member for Westbury is wrong about that. I accept that he has a valid wider concern about the nature of the inspection function; what it is designed to do, who does it and how often. However, his remarks contain a strong undercurrent of opposition to what we are trying to achieve. We are attempting to provide the public with a more reliable and effective way of ensuring that quality and standards are consistent across the NHS.

Dr. Murrison: The Minister is trying to suggest that I said things that I did not say, and is trying to put a spin on my remarks. I am concerned that having a multiplicity of regulations will detract from patient care. I stand by that 100 per cent. Practitioners want some thought to be given to how inspections might be streamlined so that they do not have to take their eye off the ball and can get on with patient care.

Mr. Hutton: I agree with the hon. Gentleman. I am not trying to spin anything; the hon. Gentleman is not a bad spinner himself. I am trying to make a number of basic observations about why we are doing this and to identify some common interests on all sides of the Committee. Whatever view we take on the detail of the proposals, I am sure that we share the common interest that they add value to the whole process.

These are new areas for us to go into in the NHS. As has been widely commented, Professor Kennedy's report, together with the work of many other bodies, has drawn attention to deficiencies in the way in which we deliver health care services in the NHS. We have an insufficient emphasis on national standards and an ineffective way of ensuring that standards are met. Our

constituents rightly expect those standards to be universal because that is the nature of the national health service. To find such wide variations in performance should call for an effective response from any Government. That is what we are trying to achieve. The Bill takes the responses forward in an important way, widening the remit of the CHI and giving it a greater independence from the centre.

I have a great deal of sympathy with amendment No. 155, moved by the hon. Member for West Chelmsford. It seeks to achieve an essential aim, and we will have to make sure that there is effective co-ordination. As the hon. Gentleman will be aware, Professor Kennedy said that we should look into these issues in relation to how the inspection process develops. He referred to the need for a council for quality. We are looking carefully at those issues in response to Professor Kennedy's report. We have the power under Section 20(2)(a) to do precisely what the hon. Gentleman is asking us to do. Those are the powers to which the hon. Member for Oxford, West and Abingdon has taken such grave objection.

One part of the Opposition says that we should have these powers—I say that we already have them—while the other part of the Opposition says that we should remove them. There is obviously a difficulty in that position; however, I know that the Opposition parties do not co-ordinate their amendments. I have sympathy with the hon. Member for West Chelmsford's amendment No. 155, although for reasons I have outlined we already have the power to do what he is asking us to do.

I have absolutely no sympathy with the hon. Member for Oxford, West and Abingdon's amendment No. 162, because it cuts across the need to ensure effective co-ordination of the work of the various inspection functions. It is important that the Secretary of State has responsibility for this area because he is responsible for the inspection arrangements that apply across the national health service. That is perfectly legitimate.

Mr. Burns: I was interested to hear the Minister say that he believes that, under the 1999 Act, the Government already have these powers. Will he tell the Committee whether since 1999 there has been a move to use these powers in a co-ordinating role or whether he sees them as powers that will be used and developed once the Bill becomes law?

Mr. Hutton: We have not used the powers to specify issues relating to co-ordination. We have, however, issued two sets of regulations under the powers that deal with how the commission should carry out its functions of advice or information on clinical governance arrangements, local reviews, national service reviews and investigations. We have used the powers in those areas but we have not exercised them in relation to the areas sought by the hon. Gentleman. If we need to do so, we shall. That is why the powers exist; we will not hesitate to use them if that will ensure proper co-ordination.

Dr. Harris: The Minister believes that he is being clever in pointing out that I am seeking to remove a paragraph under which this amendment hangs. It is surely not beyond the wit of Government to ensure that the Commission for Health Improvement and the other bodies co-ordinate without sacrificing the supposed independence that the commission is given by the retention of subsection (2)(a) and (b) and, as the hon. Member for Wyre Forest pointed out, subsections (3) and (4). I am grateful to the hon. Gentleman for showing how the amendment could be made even more inclusive with respect to independence. The choice is not one or the other. The commission or the other bodies concerned could act as amendment No. 155 would require, or the Government could establish limited powers specifically to secure co-ordination, without the need for the wide range of powers that they want to take and retain under the clause.

12 noon

Mr. Hutton: That is the hon. Gentleman's view, but not mine, of my argument and the powers in question. I understand that the hon. Gentleman wants to secure the greater independence of the commission. So do we, and that is what we are bringing about by the Bill. The argument between the hon. Gentleman and me is probably about who is best placed to ensure, overall, the co-ordination of the work. It is perfectly reasonable to expect the Secretary of State to have responsibility for that function. He could discharge the responsibility for ensuring effective co-ordination, assuming that that is the hon. Gentleman's aim, without compromising the independence of the work done by the commission when it inspects local trusts and reviews arrangements as he described. We disagree on the point and I cannot explain it in any other way.

Mr. Burns: I understand that the Minister must be careful in his use of language. However, given that he has expressed sympathy with our amendment, and given that the powers that he says already exist to carry out its intention have been used in other contexts, does he anticipate that the Government are likely to issue regulations to co-ordinate visits to minimise disruption and other problems?

Mr. Hutton: We certainly need to think carefully about that, although I shall not announce that regulations are being prepared; they are not. With the greatest respect to the hon. Gentleman and the Committee—I am not trying to hoodwink the Committee—some of the issues that have been raised relate to the way in which the Government should respond to Professor Kennedy's recommendations. He was concerned about those issues. The Government have not yet responded but will do so, I hope, in the near future. We shall then be able to conduct the appropriate debate and reflect on any need for further action.

The argument is about ways and means. The argument made by the hon. Member for Oxford, West and Abingdon is a more fundamental one about

[Mr. Hutton]

principle and independence. I think that we can secure the greater independence of the commission, but I also think that we need to retain the power to secure effective co-ordination. Those two elements are not contradictory.

The concern of the hon. Member for West Chelmsford is effective co-ordination. We have the powers to secure that, and will use them if that is necessary, and in the light of our response to Professor Kennedy's report.

Mr. Heald: The bodies for which, according to the BMA, co-ordination is needed are the medical royal colleges, the Audit Commission and the patients forums. We shall later debate a provision dealing with consultation with the Audit Commission, so perhaps that matter is less pressing, but what of the medical royal colleges and the patients forums? Would co-ordination be possible, or is their remit so independent that they would be entitled to visit at any time, and would they perhaps not welcome co-ordination, because of their role? Is there a problem in that respect?

Mr. Hutton: There is not a problem. There just are no statutory powers. The Secretary of State has no statutory powers to specify where, and in what circumstances, the medical royal colleges should exercise their functions, and nor should he have any. Those are properly issues of professional regulation and they should be matters of professional expertise within the medical royal colleges. The same is true of the General Medical Council, which has a remit and responsibility in the same context. We need clarity as to whom we are talking about. There is clearly a responsibility on the Secretary of State to co-ordinate the agencies for which he has responsibility, to avoid some of the negative effects that Opposition Members have identified. However, the extent of that responsibility should be clear, and it does not reach the medical royal colleges.

The issues have been pretty widely aired. I have sympathy with the point made by the hon. Member for North-East Hertfordshire. We do not think that it is necessary to amend the Bill to achieve what he wants. We already have the necessary powers. We shall consider all the issues in the round soon, when we respond to Professor Kennedy's report.

Mr. Burns: The debate has been extremely useful. I am grateful to the Minister for the points that he has made, especially his commitment—I hope that that does not misrepresent him—that, once the Government are in a position to reflect further after responding to Kennedy and on any other relevant issues, he and his colleagues will remember the debate and the sympathy that he had for the aims of our amendment, which he believed were already covered by the Health Act 1999.

Mr. Hutton: I shall certainly do that. I should have referred to the fact that the current process of inspection is co-ordinated. There are already memorandums of understanding at work between CHI, the Audit Commission, the health service ombudsmen, the General Medical Council, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the National Clinical Assessment Authority and other agencies.

Mr. Heald *rose—*

Mr. Hutton: I am intervening on the hon. Member for West Chelmsford, so the hon. Member for North-East Hertfordshire cannot intervene on me.

We have not used our statutory powers to oversee the co-ordination, but we have developed protocol to ensure that people do not tread on each other's toes.

Mr. Burns: I am grateful to the Minister for that interesting information.

Dr. Harris: Will the hon. Gentleman give way?

Mr. Burns: I should like to finish my point first. What the Minister said came as a surprise to me. Would he be prepared to place the guidance in the Library so that we may all benefit from reading it?

Mr. Hutton: If it helps the hon. Gentleman, I will write to him and other members of the Committee to set out the memorandums of understanding.

Mr. Burns: I am extremely grateful to the Minister for that commitment.

Dr. Harris: I do not plan to press my amendment, but I want to ask the hon. Gentleman whether he shares my concern that the Government say that the only way to achieve the aims that he, the BMA and I want in terms of co-ordination, to varying extents, is to retain powers in the Bill that I would like removed in the cause of greater independence for the Commission for Health Improvement. There is at least a strong argument that co-ordination could be made much more specific without the wide-ranging powers that the Government seek to retain, perhaps as a crumb to deliver some of the co-ordination that the hon. Gentleman wants.

Mr. Burns: I should like to reflect on what the hon. Gentleman has said when I have read the guidance that the Minister has kindly offered to make available.

Mr. Hutton: It is not Department of Health guidance. It is protocols and understandings reached between the various bodies.

Mr. Burns: I should like to reflect on the subject once I have seen that guidance. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause stand part of the Bill.

Mr. Heald: The Opposition support the extension of the powers of the Commission for Health Improvement. However, we are concerned about the co-ordination issues, some of which we have touched on, and we should like the Minister's response on two other issues.

Subsection (5) refers to CHI co-ordinating or consulting the Audit Commission about its studies for improving economy in services. There has been some comment on that, and some concern has been expressed that it might reduce the role of the Audit Commission. Page 13 of this month's *Health Service Journal* prints an article that suggests that the real losers will be other inspectors at the Audit Commission, which will now have to consult CHI on its value-for-money inspection programme. The article refers to the commission's role as being to identify failings in the way in which NHS bodies are run, and that seems like a move into corporate governance that could push the Audit Commission to the margins.

The Audit Commission has a proud role in exposing the state of the NHS, as the Minister will no doubt recall from its recent report. Can he assure us that the role or at least the function of the Audit Commission will not be diminished, and that we will continue to have the active and independent scrutiny of what occurs in the NHS so that we know the waiting time position and how hospitals perform in terms of provision of service?

A great deal of power has been given to what remains a fledgling organisation; one that is still developing. Although many of us would say that the CHI has had its successes, it would be wrong if work such as that done by the Audit Commission did not continue. Will the Minister assure us that at least the nature of the work will remain?

The National Care Standards Commission will have a role in considering independent and private sector premises, in much the same way as the CHI does where patients are cared for under the NHS. However, I want to ask the Minister about the overlap. The NCSC starts work in April 2002, and will inspect and regulate health care in the independent and voluntary sectors. The BMA has suggested that it might be better to avoid the overlaps and have a single inspection regime that merged the CHI and the NCSC. It suggests that that would have the significant benefits of ensuring a uniform and consistent standard between the NHS and other sectors, standardising the quality of care and avoiding the anomaly of two different bodies inspecting a pay bed in an NHS hospital and a private hospital where NHS patients are often treated.

Today's leak on the possible BUPA contract is relevant. If patients were to go to diagnostic centres in the private sector and have operations in free-standing surgical units, the commission would clearly want to examine such services from time to time.

Dr. Harris: As would the Audit Commission.

Mr. Heald: Indeed.

Dr. Harris: We do not want to become too distracted, but the Audit Commission might want to consider whether such services gave value for money. The subject is interesting, as the hon. Gentleman is rightly saying, because of the split functions between the CHI and the NCSC.

Mr. Heald: The hon. Gentleman makes a good point, although it struck me that he might almost be trespassing into party-political territory for a moment. Perhaps not.

Dr. Harris: Heaven forfend.

Mr. Heald: Heaven forfend indeed. Two bodies—one set up to deal with the private sector and the other to deal with the state sector and treatment under its aegis—could inspect the same premises. Of course, the commission would be able to use the expertise it gained from NHS inspections in dealing with the private sector. The same limited pool of expertise might be used more effectively, and it would complement the Government's plans to expand the involvement of the private sector in the NHS.

Section 9 of the Care Standards Act 2000 dealt with co-operative working. It is true that the CHI and the NCSC cannot carry out functions on each other's behalf but the measure, as with so many health service measures, is a cumbersome way of doing things. Would it not be possible to establish a single regime for the NHS and the independent health care sector?

Will the Audit Commission's role be diluted? Would it not be wise to merge the roles of two bodies that will do the same work in different sectors?

12.15 pm

Mr. Peter Atkinson (Hexham): My hon. Friend expressed many of the concerns that I was going to express on the relationship between CHI and the Audit Commission, but the Minister may be able to help me on one or two details. Subsection (5) is opaque, in that it amends the Audit Commission Act 1998 to allow CHI to do something that it was allowed to do under the Health Act 1999. However, the explanatory notes, which are always helpful in such matters, say that

"the Audit Commission must consult the Commission for Health Improvement on its programme of Value for Money studies in relation to the National Health Service as part of better co-ordination of regulation of the NHS."

I am confused by the question of regulation, as the Audit Commission is not a regulatory body but a body that considers issues related to value for money.

Mr. Heald: Does my hon. Friend agree that the Audit Commission's role should not be diminished, especially if the weekend press reports that the NHS is wasting between £7 and £10 billion are accurate?

Mr. Atkinson: Indeed so. My hon. Friend emphasises the crucial role that the Audit Commission plays in the NHS.

The 1999 Act empowers the Commission for Health Improvement to commission the Audit Commission to investigate value for money. Does the new relationship detract from the Audit Commission's right to do its own fishing expeditions? Is all its future research and investigation to be done at the behest of the Commission for Health Improvement? Conservative Members worry that CHI, for various reasons, could restrict the Audit Commission from doing what it wanted to do with a free hand, and restrict it to

[Mr. Atkinson]

investigating areas that were priorities for CHI. That would represent a loss of independence and effectiveness for the Audit Commission.

Dr. Taylor: May I ask the Minister about the extension of functions for the Commission for Health Improvement? Would he regard it as that body's duty to comment on reports from other bodies? As an illustration, I refer to the Whipps Cross report, which came out a few weeks ago but does not seem to have had the publicity that it deserved. It contained three important lessons for the NHS, and if the commission was allowed to comment on them, they could be given more publicity. The report blamed in part the rift between clinical staff and management, the use of agency nurses and the adverse effect of rating NHS hospitals for waiting times in accident and emergency departments. The commission should be able to comment on such reports and to make the facts more widely known.

Dr. Harris: I have a number of questions. The first is about subsection (2)(a), which replaces the phrase

"particular types of health care"

with the words "health care". I presume that it is not simply a desperate desire to save words. Did the original wording restrict what the Commission for Health Improvement could investigate?

My second question relates to subsection (2)(c), which provides for an extra function for the commission:

"the function of conducting reviews of, and making reports on, the quality of data obtained by others relating to the management, provision or quality of, or access to or availability of, health care for which NHS bodies or service providers have responsibility".

What is covered by "others"? Does it include some of the questionable performance figures that resulted from the star performance traffic-light system of nonsense performance management to which the health service was recently subjected, which was mentioned in the Whipps Cross report referred to by the hon. Member for Wyre Forest? What is envisaged?

Subsection (2)(c) concludes by stating that the commission will have the function of conducting reviews and making reports on

"the validity of conclusions drawn from such data, and the methods used in their collection and analysis".

Will that be a review of whether performance monitoring is rational—if so, it would be welcome—or is it based on some other proposal? It would be useful if the Minister were to give some examples.

Mr. Heald: Does the hon. Gentleman consider that it might be worth questioning the Minister on whether, for example, the provision would cover the confidential national inquiry into perioperative deaths and cancer treatment, which was publicised today by the media? One of the inquiry's conclusions is that the quality of data and the difficulties faced as a result of poor hospital information systems has been a substantial problem. Should not the CHI be investigating such issues?

Dr. Harris: Certainly. It would help if the commission could consider the quality of audit data and information in the NHS. That function might also allow the commission to compare the comprehensive, careful work done by successive confidential inquiries into perioperative death, which are based on clearly established data collection with rational end points, rather than investigate whether accident and emergency beds have wheels. The latter point has never been of much interest to those patients whom I have treated. They want to know when they will be triaged, when they will see a doctor, when they will be given a management plan and when they will get a bed on a ward to receive the privacy and care that they require. They do not particularly care what sort of bed or trolley they happen to be on. Will the Minister reassure me that that function will bear down on the rationality of outcome measures to which the NHS is subjected, which are of variable quality?

My third question is why the clause does not repeal sections 20(3) and (4) of the 1999 Act. Subsection (3) states:

"The Secretary of State may give directions"—

it does not even say that he should make regulations—

"with respect to the exercise of any functions of the Commission."

Subsection (4) states:

"The Commission must comply with any directions under this section."

The hon. Member for Wyre Forest originally raised the issue. The provisions give the Secretary of State wide-ranging powers to tell the so-called independent Commission for Health Improvement what it should do and how and when it should do it, and the commission must comply. Why must those powers be retained if the commission is still independent? Under what circumstances would the Secretary of State's directions be so lacking in obviousness that an independent commission would not see the need to comply with them? What directions has the Secretary of State already issued under section 20?

Mr. Atkinson: The hon. Gentleman raises a pretty good point, which I tried to raise earlier. Like him, I cannot understand why the Secretary of State needs so many powers of direction. I am also concerned that, at the next stage, the commission can instruct the Audit Commission. In effect, a ministerial chain of command runs right down to the independent Audit Commission.

Dr. Harris: I listened carefully to the hon. Gentleman's valid points, and I come now to the provision that he mentioned.

According to the explanatory notes, clause 12(5)

"provides that the Audit Commission must consult the Commission for Health Improvement on its programme of Value for Money studies in relation to the National Health Service as part of better co-ordination of regulation of the NHS."

That may be sensible. Indeed, when we debated the previous group of amendments we discussed the need for greater co-ordination. In response to an intervention by the hon. Member for West Chelmsford, I argued that it was possible to specify a requirement for greater co-ordination in the Bill. According to the explanatory notes, the co-ordination

between the Audit Commission and the Commission for Health Improvement is a direct consequence of the clause. I accept that there might be concerns about subordinating the power of the Audit Commission, but whether or not that is a good thing, co-ordination is possible.

My argument earlier was that a duty of co-ordination could be placed on other bodies, even non-statutory ones. The Minister suggested that the Government were not keen to do that in the way that I suggested. I think that that was an excuse to allow the Secretary of State to retain much wider regulatory powers. That would enable him to curtail the independence and range of functions that we want for the Commission for Health Improvement. That perhaps explains the plea in the Kennedy report for the commission to be independent.

Finally—I should perhaps have raised this subject in relation to my second point—clause 12(3) refers to the additional functions

"of conducting reviews and of carrying out investigations".

Those include:

"(a) the collection and analysis of data, and

(b) the assessment of performance against criteria."

I should be grateful if the Minister would explain what is behind that. I do not know what he is after, so I make no judgment about whether it is a good or a bad thing. Does he want the Commission for Health Improvement to have a wider performance-management function? That would mean a large commission undertaking regular inspections in some detail. I am not making a criticism, but I should be grateful for an explanation. Will that mean assessment of performance against criteria in individual cases—something that I should have thought would be already covered by the functions of the Commission for Health Improvement?

Alternatively, will it mean comparison of like with like across a range of hospitals, with attention paid to including all those that are comparable? That would seem to entail a large programme of work, carried out, in principle, by commissioners, who should be checking performance, and either by what are to become strategic health authorities, or under some of the performance functions of what will soon be only four regions of the NHS executive, or whatever it will be called in future.

12.30 pm

The clause raises a series of issues that the explanatory notes do not deal with in sufficient detail. Specific examples of the powers that the Government envisage with respect to the new Commission for Health Improvement would provide helpful elucidation.

Mr. Hutton: We should remind ourselves of the purpose of clause 12. In several important respects it is a significant provision. It would extend the commission's functions so that it could review any aspect of NHS care. Opposition Members have not mentioned its provisions with respect to publication of reports; a subject that I should have thought would be dear to their hearts. It also requires the Audit Commission to consult the commission with respect to its value-for-money studies.

There has been some misunderstanding about what subsection (5) is intended to achieve. Clause 12(5) does not in any way affect the functions of the Audit Commission, or what it chooses to do and the way that it discharges its functions. It is intended simply to advance the cause of co-ordination, which I understood that Opposition Members supported, and which we have spent the past hour and half discussing.

At the moment, the Audit Commission has an obligation to consult the Secretary of State. We want, under the Bill, to shift responsibility so that it becomes more independent of the Government. It makes sense, in the pursuit of co-ordination, for the Audit Commission to be given a responsibility to consult the CHI, which will discharge the relevant aspect of the work of monitoring the national health service.

We are not trying to bamboozle anyone or engage in a cloak-and-dagger operation to neuter the Audit Commission. The Audit Commission does an important job and highlights the issue of value for money in the national health service. Clause 12(5) does not affect the discharge of the Audit Commission's functions at all, but simply speeds and aids the process of co-ordination.

Mr. Heald: As I explained in my opening remarks, the worry is that the Minister is trying to bring about a situation in which a body is inspected either by the Audit Commission or the CHI, but not by both—thus diminishing the role of inspections on value-for-money issues and of the Audit Commission—and that the consultation in question is intended to be about commissioning issues of the type referred to by my hon. Friend the Member for Hexham (Mr. Atkinson). Will the Minister toy with those points a little longer?

Mr. Hutton: I shall not toy with them longer, because I have already made matters clear. The clause does not affect the responsibility of the Audit Commission for conducting value-for-money inspections. That stays with the Audit Commission. The Bill does not propose that responsibility for value for money should move to the Commission for Health Improvement. The Bill simply ensures that the Audit Commission, which now has responsibility for performance monitoring in the NHS—as it will under the Bill—has a responsibility to notify the Commission for Health Improvement about its value-for-money exercises. It does not seek to shift responsibility for value-for-money exercises and studies to the CHI. That is clear from the Bill.

Mr. Atkinson: It is a fine point, but if the Audit Commission decided to investigate an aspect of the health service on a value-for-money basis, would it have to submit its proposal for an investigation to the Commission for Health Improvement and seek its approval? If the commission withheld its approval because the Audit Commission's investigation might obstruct another investigation, would the Audit Commission withdraw? That is the central issue.

Mr. Hutton: If the hon. Gentleman had read the Bill, it would be obvious to him that it did not affect those issues. The Bill does not state that the Audit Commission must get the approval of the Commission for Health Improvement before it conducts a value-for-money study. Is the hon. Gentleman looking at the same Bill? I have a strong suspicion—I do not want to labour the point—that there is a make-work scheme under way among Opposition Members. They must be looking at a different Bill.

Mr. Heald: On a point of order, Mr. Hurst. Is it in order for the Minister to say such a thing when the *Health Service Journal* has raised this important issue?

The Chairman: It is in order. In debate, Members hear what other Members say.

Mr. Hutton: I accept that ruling, Mr. Hurst. However, it is clear that the points raised by Opposition Members have nothing to do with the Bill.

Mr. Atkinson *rose—*

Mr. Hutton: I have already given way to the hon. Gentleman. He wants to detain the Committee, whereas I want to move on. The Committee understands—I hope that my hon. Friends do—that clause 12(5) simply provides for sensible co-ordination. It does not affect functions or responsibilities. It does not transfer responsibility for value-for-money studies from the Audit Commission to the Commission for Health Improvement. Anyone with a fair mind who examines clause 12(5) would reach that conclusion.

The other point raised by the hon. Member for North-East Hertfordshire concerns the National Care Standards Commission. Nothing in clause 12 affects that body. I understand that he might want to explore the wider issue of who inspects, for example, private hospitals. That would be sensible, as private hospitals may be providing more care for NHS patients in future. Those issues are dealt with by amendments that I have tabled to clause 13, which makes it clear that the responsibility for the inspection function in relation to NHS-funded patient care lies with the Commission for Health Improvement.

I can understand that there is an argument about the wider issue of the co-ordination of functions between the National Care Standards Commission and the CHI—Opposition Members have expressed their views on that. We have made it clear in the Bill that the NCSC and the CHI can co-operate in the discharge of their functions, particularly in relation to the functions that we have discussed today. Parliament has left those matters to those bodies in previous legislation and a sensible and fair balance has been struck.

The hon. Member for Oxford, West and Abingdon raised several questions about aspects of the clause. Subsection (2)(a), in which he was interested, will enable CHI in future to carry out more general reviews of services provided to NHS patients. That is why we have included that wording in the Bill. The hon. Gentleman also referred to subsection (2)(c), which will enable the CHI and the new Office for Information on Health Care Performance within that body, for which clause 14 makes provision, to carry out clinical audits for the first time, including those currently within the work programme of the National Institute for Clinical Excellence. The hon. Gentleman asked me who might be covered by the term "others". The term includes not only NICE, but the work of the royal colleges in that regard.

The hon. Gentleman's third point concerned clause 12(3), one of the most important provisions in the clause, which was barely referred to by Opposition Members apart from the hon. Gentleman. The subsection relates to an important part of the CHI's new functions, which I want to elucidate for the hon. Gentleman's benefit. The Commission for Health Improvement, through its new Office for Information on Health Care Performance, should take over responsibility for publication of NHS performance ratings and indicators. The clause will facilitate that.

The Department is working closely with the commission to ensure a smooth period of transition towards independent publication of those data, which includes consulting the commission on the content of the next set of performance indicators, which are due next year. We expect the commission to continue working closely with the Department toward a joint publication of performance ratings and indicators in the summer of 2002. From the summer of 2003, the commission will take over full responsibility for publishing performance ratings and indicators on criteria agreed with the Department that reflect Government priorities for the health service. It is part and parcel of the greater role and independence of the commission that it should assume responsibility for what I acknowledge—as I am sure does the hon. Gentleman—is a crucial area in determining progress toward higher quality in the NHS.

Dr. Harris: I welcome most of the Minister's comments, for reasons that I have previously given in terms that were intended to be acerbic about the current quality of the outcome measures and performance indicators. The Minister referred to criteria set out by the Government to reflect their political priorities. It is arguable that that is the wrong approach and that the criteria should be oriented towards quality and value for money, not political priorities. Surely it will be difficult for an independent commission to stomach basing its work on political priorities rather than better quality health care and value for money.

Mr. Hutton: There is a tautology in the hon. Gentleman's argument. Throughout the debate he has bemoaned the fact that the clause is about shifting the blame, but he has a go at us when we say that it is our responsibility to fix the priorities for the national health service. It is our responsibility to do that. It would be quite inappropriate and wrong for this House to shift lock, stock and barrel the responsibility for setting the priorities for the national health service to the Commission for Health Improvement. I am sure that, if we did so, the hon. Gentleman would be popping up and down at Health questions, saying that

we can no longer hold Ministers to account. He obviously has not thought through his position. It is appropriate and right for Ministers to set the priorities for the national health service. He describes those as political priorities; of course they are, because we are operating in a political context, but they are motivated purely by the desire to improve patient care. The two are not inconsistent.

Dr. Harris: We are having a useful discussion in which there is a difference of agreement. I accept some of what the Minister says. I am prepared to meet him halfway: it would be legitimate for the Minister to set priorities for the health service if he ensured that there was the same extent of independent scrutiny as there is for those who are forced to do the Government's bidding when those priorities are set. I made that point when speaking to a previous group of amendments. The Government cannot set priorities reckless as to their effect on the quality of health care and expect those who are subject to monitoring of performance and quality of delivery by the Commission for Health Improvement to take the blame. The more independent the commission is, the more important it is that the Government's priority setting and directions are subject to inspection.

Mr. Hutton: Believe it or not—my hon. Friends will probably be surprised to learn this—the hon. Gentleman is supposed to be providing the independent scrutiny. That is his job; it is the job of all Members of the House. With the greatest respect to the hon. Gentleman, it is not our job to give that responsibility to the Commission for Health Improvement. We need to inject an air of realism into the debate. The hon. Gentleman's argument is largely academic; it is a debating point. The important function that we have in the House should not be supplanted by giving the role of scrutinising Ministers to the Commission for Health Improvement. That is not right. It does not make political or constitutional sense.

In the clause, together with other provisions in the Bill, we are providing the Commission for Health Improvement with a new range of powers and a substantial independence that will allow it to do its job effectively. It will be difficult; let us be clear about that. We are giving the commission new responsibilities; we are distancing it from Government and placing in its hands an important set of tools that will better inform the debate about the future of the national health service. But it remains absolutely right for Ministers to set priorities.

12.45 pm

The hon. Member for Wyre Forest made a fair point about the independent review that the trust at Whipps Cross organised following the tragic death of a patient in accident and emergency. It was a terrible case, and the trust was right to get an independent review of what was happening in accident and emergency. The report has been published and raised several issues that needed to be addressed.

The hon. Gentleman asked me whether the Commission for Health Improvement would be able to comment on the report. I do not think that that would be a sensible role for CHI. As a consequence of the independent review at Whipps Cross, the CHI will now conduct an accelerated review of clinical governance arrangements in the trust. That is the right balance. It should be within the remit of any trust to call in independent reviews when things go wrong; we do not want to stop that. The CHI's role is different, as it is about ensuring the best safety and procedures across the service as a whole. The debate has been long.

Dr. Harris: I want to draw the Minister's attention to some questions of mine that he has not tackled, which were on the continued inclusion of provisions in section 20(3) and (4) of the Health Act 1999. I asked why the powers to give direction were included, why it was felt that the so-called independent commission must comply with such directions, what was the purpose and what directions he had already issued under that section.

Mr. Hutton: In general terms, the provisions are necessary reserve powers that a Secretary of State needs. We should not lose sight—I am sure that the hon. Gentleman has not done so—of the fact that public money sustains the CHI. I am sorry if I have given him a lesson in constitutional theory and practice, as that was not my intention, but as he knows Ministers are accountable to the House for the use of public money, and long may that continue. Without labouring the point, we need the tools if we are to discharge that responsibility. He and others would be the first to criticise us if the essential procedures to do so were not in place. We have not yet issued any regulations under section 20(3) of the 1999 Act.

If the hon. Gentleman were unhappy about section 20(3) and (4) of the 1999 Act, he could table another amendment to clause 12. He has banged on at length today, but has failed to table an amendment to deal with his point, and he has had plenty of time to do so. Perhaps I am making a rod for my own back for the debate on Report. I look forward to discussing the subject with him if he wants to push it on the Floor of the House, but I think that the powers are a necessary reserve set of arrangements to ensure proper use of public funds. They will not be used in an attempt to subvert the independence that we think should rightly rest with the Commission for Health Improvement, but they are essential in the overall scheme of things to ensure proper accountability for public funds.

Mr. Atkinson: From time to time, the Minister takes a waspish tone with Opposition Members. He accused me of not having read the same Bill as him, and my hon. Friend the Member for West Chelmsford of being a make-work lawyer. That is a little unfair. If I were cynical, I would suspect that the Minister had chided us for not making points when he had a full brief, as he obviously had, on subsection (3) but had accused us of not reading the Bill properly when he did not have a full brief, as I suspect was the case on subsection (5). That is not helpful to our proceedings. I did not find any reason for talking about subsection (3) because the

[Mr. Atkinson]

provision was manifestly crystal clear. Our job is not to praise parts of the Bill but to question other parts of it about which we are uncertain or unhappy.

The Minister said that he and I were reading different Bills in relation to subsection (5). I remind him that the subsection reads:

"In section 33 of the Audit Commission Act 1998 (c.18) (studies for improving economy etc. in services), in subsection (6)(c), after 'Secretary of State' there is inserted ', the Commission for Health Improvement'."

Who on earth could understand that? I do not have a copy of the Audit Commission Act 1998 but even if I did, the meaning would not be clear. As most members of the Committee would do in this situation, I turn to the explanatory notes, which are normally helpful but in this case say something quite different from the conclusion that one might draw from the Bill. The notes refer to a

"better co-ordination of regulation of the NHS."

That raises serious questions in the minds of Conservative Members about the independence of the Audit Commission when the Bill is enacted. We are entitled to ask the Minister whether that body's role will be compromised.

Mr. Heald: Did my hon. Friend share my confusion when the Minister suggested that the clause delegated to CHI a role of consultation that had previously belonged to the Secretary of State, when subsection (5) suggests that CHI and the Secretary of State will both be consulted? As with so much of the Bill, the Secretary of State does not give away any powers.

Mr. Atkinson: Precisely, which is why the Committee has spent some time discussing the issue—it is not a make-work discussion, because we are playing our essential role of considering such matters. The clause is crucial, and it would be a pity if we allowed it to be added to the Bill simply because the Minister became irritated with us for spending time on it.

I listened carefully to what the Minister said, but I was still not certain whether the Audit Commission's independence would be maintained when the Bill was enacted. I shall read the record carefully to see whether the Minister's assurances are copper-bottomed or whether the Audit Commission's powers are, unfortunately, to diminish.

Dr. Harris: The Secretary of State has not given a satisfactory explanation, although he may have persuaded himself that he has. He likes to have it both ways. First he says that members of the Committee would be the first to criticise; then he claims that we are not giving adequate scrutiny.

I made it clear that the Government's political priorities, such as maximum waiting times, may distort clinical priorities, and are bad not only in their own terms but for patients and quality. The Minister has shown that he sees no role in the matter for the so-called independent Commission for Health Improvement. He will simply say, "No, it isn't bad," while I shall say, "Yes, it is," and we shall never be able to ask CHI—or, I suspect, if legislation is consistent, the Audit Commission—to express a view on whether his policy has had an adverse impact on some patients.

Mr. Hutton: Should priorities for the NHS be set by the Commission for Health Improvement or Ministers?

Dr. Harris: There are two separate questions. Should priorities in the NHS that have an impact on quality of care be set by Ministers and, if so, should that priority setting be subject to quality audit to ensure that it does not act against the interest of patients? The Minister may think that every decision, direction and circular issued by the Department of Health will be carefully scrutinised by Opposition Members. That is certainly the case for the Liberal Democrats, but I would not like to speak for Conservative Members. Nevertheless, it is difficult to ascertain through data collection whether we are right in our concerns or he is right in his reassurances, when they are scrutinised.

The Minister looks puzzled, so I will restate my point. First, should Ministers set priorities, given that that may imply micro-management—an allegation frequently made by those on the Conservative Front Bench? More important, regardless of whether it is right or wrong for priorities to be set, we would all agree that it would be wrong to set priorities that act against patients' interests and in the interests of politicians in power. The Minister may not agree with that, but I do not think that it is a contentious issue. In the end, arbitration will be needed to elucidate the matter for the public, because we would both aver that some priorities do not damage the interests of patients, but I would aver that some do. It would be useful if the Commission for Health Improvement could consider the issue, particularly given the Government's claim that it is independent.

That brings us to the key point. The Minister boasted about new subsection (1A), which gives the so-called independent Commission for Health Improvement the

"functions of conducting reviews and of carrying out investigations",

including

"(a) the collection and analysis of data, and

(b) the assessment of performance against criteria."

He specified that politicians would impose the criteria. The commission will not have the freedom to question them and will be bound by them when it comes to end points and outcomes. It will be asked how a trust is performing on maximum waiting times, without being able to question whether those act against patients' interests. The powers in sections 20(3) and (4) of the 1999 Act force the commission to comply with any directions given under that section, which might include directions not to criticise the criteria against which they should measure performance. That does not reassure us that the commission will be as independent as the Government claim.

If the Government think that independence is so important, why do they not make the commission independent? One could take the view that the Government have a job to do, that they should determine what they believe to be the quality issues and that the commission should be their tool to ensure that the service does their bidding. In that case, however, they should not claim that they are making the commission independent. The more independence they give it, the less able it will be to do their bidding. That is why the Government seek to have it both ways. They claim that sections 20(3) and (4) of the 1999 Act simply govern the appropriate use of public money. That means that similar provisions would have to be defended using the wide power to give directions and the clear requirement to comply with them that is placed on the commission. Such provisions would have to be reflected in every other statutory body in this area. The Government clearly seek to have it both ways, so I accept the Minister's invitation to return to the issue later at a later stage.

Mr. Heald: I was not satisfied on two issues, although we are broadly in favour of the clause, as I said. I shall leave my remarks about the work of National Care Standards Commission until the next group of amendments.

The Minister is right to say that subsection (5) simply provides for the Commission for Health Improvement and the Secretary of State to be consulted on Audit Commission studies on improving economic aspects of services. However, section 21 of the 1999 Act already contains detailed provisions on the way in which the Audit Commission and the Commission for Health Improvement should interact. The concern is that the co-ordination of their work could sideline the Audit Commission.

The explanatory notes say that the purpose of subsection (5) is to improve co-ordination. They state that consultation must be carried out

"as part of better co-ordination of regulation of the NHS."

The Minister is saying that the provisions strengthen co-ordination, but he cannot turn round in Committee and say that the Government are merely delegating some responsibility to the Commission for Health Improvement. The Secretary of State must still be consulted, so he loses nothing. The commission gains the right to be consulted against the background of arrangements for joint working that provide that the Audit Commission may undertake functions—

It being One o'clock, THE CHAIRMAN *adjourned the Committee without Question put, pursuant to the Standing Order.*

Adjourned till this day at half-past Four o'clock.

THE FOLLOWING MEMBERS ATTENDED THE COMMITTEE:

Hurst, Mr. Alan (*Chairman*)
Atkinson, Mr. Peter
Burnham, Andy
Burns, Mr.
Challen, Mr.
Fitzpatrick, Jim
Hall, Mr. Mike
Harris, Dr. Evan
Havard, Mr.
Heald, Mr.
Hutton, Mr.
Moffatt, Laura
Murrison, Dr.
Taylor, Dr. Richard
Thomas, Gareth
Touhig, Mr.
Ward, Ms

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