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Public Bill Committee

HEALTH AND CARE BILL

Twelfth Sitting

Thursday 23 September 2021

(Afternoon)

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Monday 27 September 2021

The Committee consisted of the following Members:

Chairs: Mr Peter Bone, Julie Elliott, † Steve McCabe, Mrs Sheryll Murray

† Argar, Edward *(Minister for Health)*
† Bhatti, Saqib *(Meriden)* (Con)
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
† Double, Steve *(St Austell and Newquay)* (Con)
Foy, Mary Kelly *(City of Durham)* (Lab)
† Gideon, Jo *(Stoke-on-Trent Central)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Owen, Sarah *(Luton North)* (Lab)
† Robinson, Mary *(Cheadle)* (Con)
† Skidmore, Chris *(Kingswood)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
Timpson, Edward *(Eddisbury)* (Con)
Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Thursday 23 September 2021

(Afternoon)

[Steve McCabe *in the Chair*]

Health and Care Bill

Clause 66

The NHS payment scheme

Question (this day) again proposed, That the clause stand part of the Bill.

The Chair: With this it will be convenient to discuss the following:

Amendment 84, in schedule 10, page 197, line 17, at end insert—

"(1A) The NHS payment scheme must ensure that the price paid to any provider of services which is neither an NHS Trust nor an NHS Foundation Trust cannot be different from the price paid to an NHS Trust or NHS Foundation Trust."

This amendment ensures payment to private providers can only be made at tariff price to prevent competition for services based on price.

Amendment 100, in schedule 10, page 197, line 17, at end insert—

"(1A) NHS England must obtain the agreement of the Secretary of State before publishing the NHS payment scheme."

This amendment ensures that the NHS payment scheme, which sets out the prices to be paid for NHS services, is approved by the Secretary of State.

That schedule 10 be the Tenth schedule to the Bill.

2 pm

Karin Smyth (Bristol South) (Lab): It is a pleasure to see you in the Chair this afternoon, Mr McCabe. You missed the start of an exciting debate about the NHS payment system; I am sure you are grateful not to miss the end of it.

The complexities of NHS funding are hardly mentioned in the Bill, and some hon. Members may think thank goodness for that, but I urge them to take a bit more account of clause 66—as my hon. Friend the Member for Nottingham North has said, it is a short one—because we are talking about over £100 billion of taxpayers' money, rising to 40% of the Government's annual spend. It is particularly important that we understand how and where that money is spent and to be assured that it is spent effectively and efficiently.

In large part because of the data collection journey that it has been on for some 20 or 30 years, we know that the NHS is the most efficient system we could have, as has been reviewed in numerous reports during that time. We have ways of looking at variations across the country and across a city such as my own, and that can only be a good thing. There are people—I am not suggesting there are any in this Committee Room—who think the NHS is a continuous money pit, is inefficient and could be operated better in another way, and part of understanding that argument is to understand the data and the way in which the money is spent, particularly the costings.

As I said in my earlier intervention on the Minister, about the process that has now been embarked on of producing a payment system, this clause is really important and really quite concerning. We have no idea when this payment system is going to be available.

The Minister for Health (Edward Argar): Before the hon. Lady asks more questions, I may be able to reassure her by adding to what I said this morning as I have now discussed this further. I said "expeditiously"; I am willing to go further on the Floor of the Committee Room now and say that I would expect the scheme—I may be creating a hostage to fortune—to be published in the course of 2022. I hope that gives her a little reassurance; she will now hold me to that.

Karin Smyth: There is an army of accountants out there suddenly looking at their abacuses and speeding up the work they are doing.

My hon. Friend the Member for Nottingham North mentioned coding. The basis on which we know how much things cost—we can then compare things, look at efficiency and so on—is coding. We know there has been some up-coding over the years, but we also know that it took a large effort to train up and try to reward coders, who are often the lowest of admin staff, to recognise how important they are to the system.

Part of that was a drive for competition, payment by results in foundation trusts and so on, but it seems that that is all going to be swept aside by the Bill in the interests of co-operation—that is another word for collaboration, which is something we all support. I do think that running through this Bill is a problem of throwing the baby out with the bathwater. In the 1970s and early 1980s, the NHS really had no idea what things cost and what value they brought. We had no way of objectively understanding how scarce resources were being allocated. In a publicly funded system, that should worry us all, particularly as we in Parliament are the guardians of the public's money.

We can argue about how much money will be saved by not having the current system. I am not sure that much money will be saved by abolishing the current system, although the Minister may be able to assure us about this point today. I gently advise the Minister and the Secretary of State to take a great deal of interest in this and consider how the NHS will produce such a system in 16 or 17 months at the maximum, as we have just heard. The data on which the system is predicated—the collection of that data, and the use of it to inform clinical and managerial practice—will continue, but, without the incentives around competition and price and the competing agenda of recovery and the management of large hospitals in particular, it will be quite a tall order.

The Secretary of State and the Minister might want to look at the issue in a bit more detail. The Minister outlined quite a complicated process about how we will get to this scheme and a lot of consultation. Although I am all for democracy, as we embark on our conference season the Minister might want to consider at some point why a scheme should go out to quite so much review and consultation by the providers in the system.

Perhaps I could say something here about how the issue affects our local system. When we start to iron it all out and see the impact assessment on the impact—classic NHS terminology—on our local communities, there will be, for want of a better phrase, a bun fight in all our local communities. Again, as my hon. Friend the Member for Nottingham North outlined earlier, when we talk about payment by results it is, of course, acute sector trusts that are the major drivers. Mental health, learning disabilities, community services, and GP services are outwith some of that funding scheme.

Many providers then wanted to come on to the system because they felt that it was more rewarding financially and better for their bottom line. The fact that those services are outwith the scheme remains a problem. I can see why the Government want to change that, but it is not quite as simple as they might want to make out. My hon. Friend has talked much about whether we start competing on price, but now that we know that competition on price is not being permitted, that does throw out a lot of other issues, particularly those around the procurement system.

With regard to amendment 84, the Minister made reference to independent sector treatment centres and incentives for getting the private sector in under previous Governments. We can all banter about the politics of that, but the key task for the Labour Government was to incentivise and change practice in a monolithic system, to drive down waiting lists and times. The question that I leave hanging for the Minister is, given the movement to a new payment system, how will the patient voice, waiting times and waiting lists be managed and incentivised in a central block payment system, which is what I think we are looking at?

Furthermore, with regard to our amendment, the private sector, having no responsibility for education, training and the large crumbling estate, should be able to offer any kind of services at a lower price than the NHS by any logic of efficient running. Ensuring that it is not offered more is the very minimum that we should be demanding. Given that the private sector should have a lower-cost base than the public sector, perhaps it should offer a cheaper price.

Does the Minister have a view on whether paying by results will be anywhere in the new system? Are we to continue following the changes made during covid, by which I mean the block grant system, which allows for baseline costs, a bit of variation for the population, and perhaps some deduction for efficiency and top-ups for various programmes—a bit like the old days when we mysteriously drew down pots of money from the centre for various programmes across the country? What is the balance between that block funding, payment by results and programme funding? Will there be an assessment of the impact of this change, particularly on reducing lengths of stay, as a measure of efficiency in the system, or on reduced waiting times and waits for diagnostics?

It would be good to nail down a few of these key principles in the Bill. The Secretary of State should really approve any scheme and give Parliament a look in; we should understand, as local representatives, what the impact is on our local system and whether we are gaining or losing money, or whether this is just £100 billion-plus going into a central pot and then seeing what happens—that cannot be sustainable.

Private providers should certainly have no say in the rule-setting, as this is a public service; if it is not a market, it is not a market. We are going to be able to debate this only when we know what it is. Given that the Minister has given a big push to the abacuses across the country, with a deadline of somewhere in 2022, for a Bill that we are expecting to put into a new system for April 2022, this situation is not satisfactory for us as representatives. There must be some way—perhaps this will be debated when the Bill leaves this place—for us to understand the broad principles and criteria. We know that there is going to be guidance from NHS England, but if it is going out for consultation, re-consultation and re-consultation, then redrafting and at some point the Secretary of State is going to see it, at some point Parliament should have a say or have a look at that and we, as local representatives, should understand what the impact is on our local communities.

We should also understand what the impact is on the balance between the acute sector, and the community and primary sector—and mental health and learning disability services. Another real concern about the Bill, which I will keep referring back to, is the cartel between the acute trusts and this new integrated care board, and the cutting out now of GP primary care commissioners, and the rolling back on the aims of the primary care trusts to switch the movement of the NHS to be focused not just on the money and where the big money is being spent, but on the service for patients and the public.

The crucial point for the Government will be: how are they going to use the financial mechanisms that exist to recover the backlog and put the NHS back on an equal footing? We have been asked to pay more for the new part of social care as well. As we continue to ask our constituents, the taxpayers, to pay more for what is a good, efficient service that does use its money well—we know that and we want to keep knowing that—how are we going to be able to persuade them of that in the future if we have this amorphous block allocation of money and no incentive to keep focused on efficiency and, in particular, on data collection?

Edward Argar: It is a pleasure, once again, Mr McCabe, to serve under your chairmanship. I fear I may not persuade Opposition Members not to press amendment 100—but you never know, so I will try my luck. The hon. Lady made a number of points and I responded to one when she kindly took an intervention; the only caveat I should add is that that, as she has alluded to, is subject to the passage of this legislation. I would not wish to pre-judge the mood of this House. With that in mind, the aim would be to publish in 2022, in time for the start of the 2023-24 financial year, to allow those systems to do the work they need to do.

The shadow Minister, the hon. Member for Nottingham North, asked, "Why use clause 37?" I think he was referring to the clause rather than me as being a "blunt instrument"—well, I will charitably assume that he was. The reason is simply that the setting up of the payment scheme is an operational issue, and in practice—I will turn in a moment to the strategic, broad points the hon. Lady made—we would not expect to intervene in the day-to-day running of the NHS as a matter of course. However, the hon. Lady is right to say that the payment scheme and the mechanism for payments is a powerful incentive to shape activity and how the NHS operates. I can reassure her, I hope, in one respect: I will certainly

[Edward Argar]

take a close interest, within the bounds of appropriateness, as will be set out in the Bill and the guidance underpinning it, in what the payment schemes look like. She is right in terms of the impact. She is also right—again, this could be career limiting; I hope the Whip does not note this down—to highlight some of the levers and mechanisms that the previous Prime Minister, Tony Blair, used in the early 2000s to make sure the money that he was investing in the NHS was driven through system and producing results.

2.15 pm

I hope I can give the hon. Lady some reassurance that among those I have worked with and talked with in recent months are Matthew Taylor and Michael Barber, both of whom were a key part of that Prime Minister's delivery strategy and approach. I listen very carefully to what they say, as of course I do to what the hon. Lady says. We may not be accepting amendment 100, but what I can say—I hope this will not necessarily prevent her from pressing it to a Division, but that it gives her some reassurance—is that I always reflect very carefully after these sessions on the particular points she makes, because she does know of what she speaks. I will continue to reflect very carefully on the points she makes in this context.

On clause 37, blunt or otherwise, we will continue to work closely with NHS England on the development of the payment scheme through existing accountability arrangements so that it aligns with the Government's wider financial and incentivisation priorities for the NHS. I do not think that Secretary of State approval for small or minor changes to the scheme would be in line with the spirit of the Bill, in terms of operational freedom and flexibility for the NHS, but the power of direction under clause 37 does, I believe, provide a strong safeguard should it be needed. That is why I think it is the most appropriate mechanism. We may differ on what is the appropriate mechanism, but I hope we might agree that there needs to be some mechanism by which that power could be exercised and we would use clause 37. We may differ on that, but I think we have possibly come from the same position and are diverging only on the means.

The shadow Minister and the hon. Lady raised payment by results. The wider changes in the Bill, which we have discussed on a number of occasions, seek to facilitate a move to greater population health management. Therefore, as part of the payment scheme, we would expect greater incentives for commissioners and providers to focus on prevention and early intervention. I recognise that activity-based payment schemes such as payment by results do have value, as the hon. Lady suggests, including in reducing waiting times when used properly. Commissioners can still use payment by results should they wish to do so. The payment scheme simply gives local areas a greater degree of flexibility on how they want to use payment structures.

On consultation and engagement, I take the hon. Lady's point but I think, reflecting her other points about how important this is, that the level of consultation and engagement suggested is inappropriate. She mentioned conferences and I wish her a lively conference, but hopefully an enjoyable one in tandem with that.

The hon. Lady mentioned the role of Parliament. We would not lay this before Parliament in that sense, but it would be published and of course MPs would be able to table questions, secure debates and potentially even table urgent questions on it should they so wish. The mechanism is there for that scrutiny.

I want to make a final point, if I may, on the macro point about waiting lists. The context is that we are now seeking to recover waiting list times and reduce waiting lists following the impact of the pandemic on elective and other procedures. As I said earlier, I hope to give the hon. Lady some reassurance in saying that as a historian I pay heed to the lessons of the past in tackling the issue. I am looking at what the former Prime Minister did to tackle waiting lists—a different context, but the principles are the same. I believe that quality should be key: that should always be the paramount consideration.

We believe that this mechanism, coupled with our elective recovery strategy, will deliver a reduction in waiting lists and waiting times, but I will continue to reflect very carefully, as the shadow Minister suggested I might, on amendment 100 and on the hon. Lady's points. Although we cannot accept the amendments today, the underlying points she makes are valid and I will continue to reflect on them very carefully. On that basis, I commend the clauses and the schedule.

The Chair: Mr Norris, before we go to the vote I want to give you an opportunity to respond, particularly on the amendments, so we can be clear about what you are up to.

Alex Norris (Nottingham North) (Lab/Co-op): I will give a quick indication, if that is okay, Mr McCabe. I take what the Minister has said about amendment 100, and I hope that he will continue to reflect on it. At many points, the Bill reserves specific powers to the Secretary of State, but if we do not need to do so, because the Government can just use clause 37, why on earth would we ever do that? I actually think this would be a very suitable place to do it, but on that basis, I will not press amendment 100. I would like to push amendment 84 to a vote.

Question put and agreed to.

Clause 66 accordingly ordered to stand part of the Bill.

Schedule 10

THE NHS PAYMENT SCHEME

Amendment proposed: 84, in schedule 10,page 197, line 17, at end insert—

"(1A) The NHS payment scheme must ensure that the price paid to any provider of services which is neither an NHS Trust nor an NHS Foundation Trust cannot be different from the price paid to an NHS Trust or NHS Foundation Trust."—*(Alex Norris.)*

This amendment ensures payment to private providers can only be made at tariff price to prevent competition for services based on price.

The Committee divided: Ayes 4, Noes 8.

Division No. 14]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Davies, Dr James
Bhatti, Saqib	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	Robinson, Mary

Question accordingly negatived.
Schedule 10 agreed to.

Clause 67

REGULATIONS AS TO PATIENT CHOICE

Karin Smyth: I beg to move amendment 93, in clause 67, page 60, line 15, at end insert—

"(1AA) The regulations must make provision—

(a) for anyone with a diagnosis of terminal illness to be offered a conversation about their holistic needs, wishes and preferences for the end of their life, including addressing support for their mental and physical health and wellbeing, financial and practical support, and support for their social relationships,

(b) that where that individual lacks capacity for such a conversation, it is offered to another relevant person, and

(c) that for the purposes of section 12ZB a relevant authority must have regard to the needs and preferences recorded in such conversations in making decisions about the procurement of services."

This amendment ensures that the scope of the regulations as to patient choice includes those at the end of life.

The Chair: With this it will be convenient to discuss the following:

Clause stand part.

That schedule 11 be the Eleventh schedule to the Bill.

Karin Smyth: I will not push my amendment to a vote, but I seek responses from the Minister. I want to highlight the issue that we touched on earlier, and I am grateful for his comments, about how end-of-life and palliative care are the responsibilities of these new bodies.

This particularly relates to coming out of the pandemic, but even before the pandemic we had numerous reports from the Royal College of Physicians, the Care Quality Commission, the health service ombudsman and Compassion in Dying about how people approaching the end of life do not feel supported to make the decisions they are faced with, are not always given an honest prognosis and do not know what options or choices they have. I think the issue of patient choice is very important in this clause, and I feel very strongly about it. I think this could generally be stronger in the Bill, but I will particularly highlight what is in my own amendment.

Amendment 93 would enable dying people to have conversations about what matters most to them, which is the first step to ensuring that they are at the centre of any decision making about their own care and treatment, and it starts the advance care planning process. I have been fortunate in that I have had three children, and I talked through my birth plans and my choices for the whole experience very carefully. It was presented to me as part of the process of giving birth. It does not always go well, as we know—we had a baby loss event today in Parliament, which many of us could not be part of.

The principle of choice at fundamental points in people's lives as a patient is one we have embedded in the health service. Co-production of care for most incidents that we face is a fundamental part of clinical practice. Only at the point when people are most vulnerable, at the end of life, is the principle of advance care planning and co-production in their choices and prognosis something we are still not prepared to contemplate in the health service. It really is as basic as that. If I can make those choices about when I am giving birth, we should be able to make those choices when we are on the pathway of the end of our lives.

The evidence on advance care planning in order to support people on where and how they die is well made. This is about promoting earlier access to palliative care, communication, reducing conflict, helping families understand what is ahead and making the person less likely to have to go through rushed accident and emergency and distressing journeys into hospital. There is a need to start supporting advance care planning, and I would welcome the Minister's comments on where the Government now think they are on that.

A key part of this amendment is proposed new paragraph (c), on authorities and new ICBs having

"regard to the needs and preferences recorded in such conversations in making decisions about the procurement of services."

The full value of advance care planning can be realised only when individual care preferences are reflected in actual treatment decisions. Again, that is about empowering patients, something that I hope Members from across the House support.

Alex Norris: This is an important clause and an important amendment. We have said on many occasions that we want a model that promotes collaboration, rather than competition, but in doing so it is important that we do not create 42 closed shops, where a patient has little agency over their care. That will not feel right for those individuals and it risks weakening a culture of the pursuit of excellence and the best standards of care. Therefore, enshrining choice for citizens actually becomes more important in a collaborative system, so it is right that this is being addressed.

The Minister might not have a reply immediately on this, but he might be able to work with one from his officials about reports overnight in Nottingham, where there is no choice now over someone's cancer care and such care is being "rationed"—that was the word used—because of workforce shortages. That is exceptionally alarming and will lead to some dreadful outcomes for people in our city. I hope there could be a follow-up letter about what is being done to switch those services back on immediately.

Turning back to the Bill, it is right that NHS England would have the power to investigate cases and direct an ICB as to how to rectify failure. It is good that there is a provision whereby investigations can be averted by an undertaking from an ICB to rectify the failure directly; that feels like the right level to start at. I am keen to understand from the Minister how he expects a person to enter the system and enter into that mechanism. Are they likely to be expected to contact NHS England directly to trigger an investigation or will there be a local process at an ICB level first before escalation? It would seem reasonable that we should exhaust local

[Alex Norris]

options before escalating to the regulator. If that is so, what prescription will there be, perhaps in guidance, if not in the Bill, for the form that that takes, so that an ICB that is not engaging positively with an individual cannot act like a blocker to elevating that? Perhaps we could consider bringing in a trusted third party at a local level—for example, Healthwatch would very well placed.

We saw in written evidence concerns that the current plans might not go far enough. The National Community Hearing Association said in its evidence:

"Existing rights to patient choice do not go far enough and typically only apply to primary care and consultant-led services. Giving patients more choice and control over their care for non-consultant-led services, especially for long-term conditions such as adult hearing loss, results in better health outcomes and helps tackle health inequalities. We would ask the Committee to press the case for the regulations to be made under this power to expand a patient's right to choice. Regulations can do this by enabling patients to choose an NHS community provider for their hearing care where clinically appropriate. Currently only 50% of NHS regions in England offer patients this choice, resulting in inequalities in access to care."

I wonder whether the Minister has considered that and could perhaps give us his reflection on the matter.

2.30 pm

Amendment 93 is well pitched. It is an important moment to raise this issue, which has come at other times in the proceedings. This is an area that people feel particularly strongly about, for obvious and good reasons. There is the perception that we are not getting this right at the moment and this amendment gives us the chance to do so. I hope that we hear some response from the Minister on how else it might be done.

Let me turn now to the evidence from Marie Curie. Its recent survey of carers during the pandemic found that: 76% said their loved ones did not get all the care and support they needed; 64% said they did not get the care and support they needed with pain management; and 61% said they did not get the care and support they needed with personal care. Clearly, things are challenging at the moment. Indeed, this has been a challenging period, and it will remain so for a significant period of time, as our case in Nottingham demonstrates. Within the next two decades, 100,000 more people will die each year. By 2040, the number of people needing palliative care is projected to be up by 42% because of our ageing population. Again, these are all figures from Marie Curie. It is a significantly growing issue.

In my four years in this place, I have championed the TUC's Dying to Work campaign, which calls for employment rights to be frozen at the point of terminal diagnosis. This might not be quite the right vehicle for that, but it does enshrine, at the terrible point when a person receives that awful diagnosis, that at least a package of support kicks in for them. I am interested to hear from the Minister how, if not through this amendment, that might be done.

Edward Argar: Before I turn to the substance of my contribution, let me say that I am not aware of the specifics of the issue that the hon. Member for Nottingham North raised, but if he writes to me, I will pass it on to my officials and see whether I can look into it for him.

I am grateful to the hon. Member for Bristol South for bringing this important discussion on end-of-life care before the Committee today through her amendment. Amendment 93 would add a provision to the regulation-making powers in relation to patient choice, requiring that any regulations made under the power must make provision so that anyone with a diagnosis of terminal illness is offered a conversation about their holistic needs and their wishes and preferences for the end of their life. This would include addressing support for their mental and physical health, wellbeing, financial and practical matters and social relationships.

Such regulations would require that, where that individual lacks capacity for such a conversation, it is offered to another relevant person, and that a relevant authority must have regard to the needs and preferences recorded in such conversations in making decisions about the procurement of services.

It is of course incredibly important that anyone at the end of their life, whether or not they have been diagnosed with a terminal illness, has the opportunity to discuss their needs, wishes and preferences for their future care, so that they can be fully taken into account. There is already ongoing work across the health and care system to support this aim, including a commitment within the NHS long-term plan to provide more personalised care at the end of life. There is also a recently updated quality statement within the National Institute for Health and Care Excellence on advance care planning.

Furthermore, the ministerial oversight group, which was recently established following the CQC's review of "do not attempt cardiopulmonary resuscitation" decisions during the covid-19 pandemic, is also developing a set of universal principles for advance care planning to further support health and care professionals in having appropriate and timely discussions with individuals at the end of life. I hope that the reassurance that I was able to offer the hon. Member for Bristol South in our discussion on a previous clause did help.

At this moment, I will pause briefly to join the hon. Member for Nottingham North and others in paying tribute to the work of Marie Curie, which does amazing work day in, day out. Through its work on this, it has helped to raise, in the context of the Bill, the profile of this issue.

I should also say to the hon. Gentleman that I recall his work, when we were relatively new Members in this place, on the TUC's Dying to Work campaign. I have considerable sympathy with the campaign, and I pay tribute to him for his work back in the days when I was a Back Bencher and able to engage more directly with campaigns. I also pay tribute to the TUC for its work in this area, because it is extremely important. I hope that he will forgive me if I do not stray into other Departments' policy remits, but the issues that he was bringing to the fore were important ones and that continues to be the case, so it is right that I acknowledge his work.

We know that patient choice is a powerful tool for improving patients' experience of care, and we intend to ensure that effective provisions to promote patient choice remain. I do not feel that it is appropriate for it to be written into primary legislation. I am grateful that the hon. Member for Bristol South said she does not intend to press the amendment, but she makes her point.

Karin Smyth: I am grateful to the Minister for his response. He mentioned the ministerial oversight group on advanced care planning. Would he be able to indicate when we will hear from that review—if not now, perhaps in writing?

Edward Argar: I am happy to write to the hon. Lady to communicate that information to her.

We know how important patient choice is, and not just in terms of individual choice, although it is of course vital in that context, but also in helping drive the system to continuously improve. We take the view that it should be determined through regulations. We have chosen that approach to allow the legislation to be flexible and to reflect changing priorities and new policies in relation to patients' rights to choice.

The shadow Minister raised the process and mechanism for complaints. The individual would in the first instance complain to the ICB, as the commissioner and main body providing and co-ordinating health services in their locality. If they are not satisfied with that, they could then escalate that complaint to NHS England. It is not straight to the top, as we all know through our casework. We recognise and advise our constituents to go through the complaints process, and only at the final stage does it reach Ministers and NHS England or ombudsmen or other national bodies. That would be our approach.

Regulations on patient choice have previously been made under section 75 of the Health and Social Care Act 2012. Opposition Members will of course be deeply saddened that that section is being repealed by the Bill, including its procurement elements. In so doing, the Bill also revokes the regulations covering patient choice, so clause 67 ensures that patient's rights to choice continue to be protected.

The clause adds similar powers, including those relating to guidance and enforcement of the standing rules, into the National Health Service Act 2006, and introduces a requirement for the Secretary of State to make regulations on patient choice. The power to make guidance and enforcement of patient choice will be held by NHS England, following the planned merger with NHS Improvement, with the complaints process that I set out earlier. The clause will give NHS England powers, which NHS Improvement currently holds, to resolve any breaches of patient choice.

There is currently a wide range of choices that people should expect to be offered in the NHS services they use—for example, choosing a GP and GP practice and choosing where to go for your appointment as an outpatient—and the clause will allow for those and other aspects of patient choice to be preserved. The clause will make sure that, under the new model, bodies that arrange NHS services are required to protect, promote and facilitate the important right of patients to make choices about who provides those services.

We know that patient choice is an incredibly powerful tool for improving patients' experiences of care. The clause will ensure that effective provisions to promote patient choice remain, will strengthen existing choice rights and will continue to make them a requirement of the decision-making bodies that commission healthcare services. Without the clause, patients' right to choice would be removed along with section 75's removal. NHS bodies would not be under duties to protect and promote patient choice. Clause 67 reinserts the right and inserts schedule 11.

Schedule 11 provides further details of the powers given to NHS England to resolve any breaches of the patient choice requirements imposed on an ICB. It requires NHS England to publish a procedure outlining how it will resolve failures of an integrated care board to comply with patient choice, and lays out the reporting and appeals process. It also allows NHS England to treat inaccurate, misleading or incorrect information from an ICB as failure to comply, which will, I hope, encourage the full and accurate engagement of an ICB in addressing a failure.

People should expect to be offered a wide range of choices, as I have alluded to, and the clause and schedule will allow for that. NHS England will be able to ensure that ICBs are required to protect, promote and facilitate that important and powerful right. We know how important that is for individuals and for driving the right behaviours in the system and to improving care.

Mary Robinson (Cheadle) (Con): I am grateful to the Minister for highlighting this issue with such importance. We know that patient choice is vital when a person gets to those end-of-life stages and has a terminal illness. Could I request that consideration is also given to timeliness around choice-making? For some people, particularly those suffering with motor neurone disease, their disease can move quite swiftly, so timeliness in those conversations is important. I would be grateful if consideration could be given to that, and I am heartened by what I hear from the Minister.

Edward Argar: My hon. Friend is absolutely right about timeliness, both from the system, in initiating those conversations, and as something that all of us need to pay heed to as individuals. Before the pandemic and before she stood down at the 2019 election, I held an event in my constituency with the former right hon. Member for Loughborough, Baroness Morgan of Cotes, about thinking and making choices early and preparing ourselves for getting older—things like preparing a will and powers of attorney. All too often, for very understandable psychological reasons, many of us do not want to think about such things, because they are an intimation of mortality. However, it is important that as individuals and as a system and a society we think and plan early, because it can make such a huge difference to the quality of our older years or the end-of-life period.

Therefore, if I may, Mr McCabe, I commend clause 67 and schedule 11 to the Committee.

Karin Smyth: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 67 ordered to stand part of the Bill.

Schedule 11 agreed to.

Clause 68

PROCUREMENT RELATIONS

Justin Madders (Ellesmere Port and Neston) (Lab): I beg to move amendment 95, in clause 68, page 61, line 32, leave out "health care services" and insert "services required".

The Chair: With this it will be convenient to discuss the following:

Amendment 99, in clause 68, page 61, line 35, at end insert—

"(1A) The regulations must provide that no contract for the provision of the services specified in subsection (1)(a) and subsection (1)(b) may be awarded other than to a relevant authority unless a formal competitive tendering process provided for by the regulations has been followed."

Amendment 96, in clause 68, page 62, line 1, at end insert—

"(3A) The regulations must—

(a) include the power for integrated care boards to continue to commission the services provided by an NHS trust or Foundation Trust without any requirement for any re-tendering process,

(b) require that, prior to commencing any formal procurement process for a service provided by an NHS provider, where the contract value exceeds a threshold set by the relevant integrated care partnership, the integrated care board must conduct a public consultation and publish the business case for opening the service to a competitive tender process,

(c) require an assessment to be made of alternative ways of providing a service using NHS providers before a contract with a non-NHS provider may be extended or renewed,

(d) be based on the assumption that the NHS is the preferred provider of services, and

(e) require providers to pay staff in line with NHS rates of pay and to provide terms and conditions of employment at least equivalent to NHS terms and conditions.

(3B) NHS England must publish a report each year on the proportion of contracts subject to the regulations which are awarded to each of NHS, third sector, local authority and independent sector providers.

(3C) NHS England and each integrated care board must publish a plan every three years on reducing the provision of NHS services by private providers and increasing the capacity of NHS providers to provide those services.

(3D) Integrated care boards must publish, in full and without any recourse to commercial confidentiality, all—

(a) bids received for contracts,

(b) contracts signed, and

(c) reports of routine contract management."

New clause 12—*NHS as the preferred provider of NHS contracts*—

"(1) The NHS is the preferred provider of NHS contracts.

(2) NHS contracts must be provided by NHS suppliers unless the NHS supplier is unable to fulfil the terms of that contract.

(3) Where the NHS is unable to fulfil the terms of a contract, a competitive tender must be held to identify an alternative provider.

(4) For the purposes of this section—

(a) 'alternative provider' means private companies and independent sector treatment centres, and

(b) general practice and GP-led community services are NHS suppliers."

This new clause would establish NHS suppliers of services as the preferred providers of NHS contracts. Independent sector providers could hold NHS contracts after winning a competitive tender.

Justin Madders: It is a pleasure to see you in the Chair this afternoon, Mr McCabe. We have arrived back at the start: the need to end the bureaucratic, expensive and ultimately corrosive requirement for compulsory competitive tendering for health services, which led the drive from NHS England and its former chief executive to first ignore the Lansley Act and ultimately push for its repeal. It turned out that trying to implement the requirements of that Act gave rise to all the problems the Opposition foresaw a decade ago.

Has the Minister seen any impact assessment of the benefits to the NHS of removing the requirements? Is he able to give us a total amount of the cost to the NHS of this folly over the past decade? Is he able to quantify exactly how much public money has been spent on lawyers and consultants going through all the hoops that were laid down by Lansley? I am not just talking about the extra work in putting the contracts out to tender in the first place, never mind the millions that will have been spent on defending and justifying decisions taken from disappointed bidders, which is a big part of it as well. Let us not forget that, as a result of that legislation, we had the obscene spectacle of the NHS being sued by Virgin Care. That certainly was not one of the benefits trailed by the Government of the time back in 2012.

2.45 pm

This clause could be called the "we told you so" clause. It could be, putting it more charitably, the "benefit of experience" clause. It could also be called the "baby with the bathwater" clause, because although the end of competitive tendering is to be welcomed, what is now lacking are the necessary safeguards to ensure that what follows is done to high standards and does not replace one flawed approach with another. That is important because as things stand the Bill just says that regulations may be made on procurement. That is just not good enough. I am referring to the need for us to be clearer and firm on this, because of a string of dodgy contracts issued during the pandemic under emergency powers.

I want to draw the Committee's attention to a few of the key findings of the National Audit Office report on this matter to highlight that this is not just some flight of fancy, but a consistent characteristic of how the Government have operated during the past 18 months. The NAO found

"examples where departments failed to document key decisions, such as why they chose a particular supplier or used emergency procurement,"

They then compounded that error by failing to

"document their consideration of risks, including how they had identified and managed any potential conflicts of interest."

Those are not minor issues; they are fundamentals that go to the heart of what we want to see from the Government. We want higher standards of probity; we want the Government to be free of accusations of cronyism; we want to ensure transparency; and we want to ensure value for money. I would like to think that all Members would support such aims, which is why they ought to support our amendments.

Amendment 99 sets a very clear baseline that no contract under this clause can be awarded to anyone

"other than to a relevant authority unless a formal competitive tendering process provided for by the regulations has been followed."

As so many said then and say now, there is no evidence that competition among providers of healthcare in the sense of a market has had any benefits. The requirements for a market function simply do not apply to healthcare.

As was pointed out a decade ago, competition for services, as opposed to buying consumables such as tomato ketchup or cream pies, requires at least three things: an ability to specify in some kind of contractual way what exactly is being purchased; existing multiple providers of the service so described who are willing to sell it; and, crucially for healthcare, the service has to have high independence from other services, so that any failures have minimal impact.

There were some interesting contributions from witnesses in our evidence sessions on the benefits or otherwise of the 2012 regime. Saffron Cordery of NHS Providers said:

"one of the things that we really need to look at is the effectiveness of the current contracting regime, which for certain parts of the provider sector in particular is incredibly burdensome…If you sit in a mental health or a community trust, you are subject to a whole host of retendering, which can have a potentially far-reaching impact on your trust's sustainability or the future operation of key services."—[*Official Report, Health and Care Public Bill Committee,* 7 September 2021; c. 53, Q66.]

The attempt to drive a market into our NHS was perhaps the worst policy mistake of the current era, yet the warnings were all there. They were just brushed aside by a determined coalition Government. I am tempted to say that the Minister should listen to us this time, even if his predecessors did not a decade ago. The healthcare system with the highest level of market design is in the USA. It is also the worst-performing and the most expensive. The US may have some of the very best healthcare, but it is for a very, very tiny minority, and the price for that is paid by everyone else. Why would we want to emulate the worst?

We do not shed a tear for the end of this era. We welcome the new era of provider selection. The provider selection regime comes not from the Bill, but from an NHS England document that is mostly benign, but does give scope for improvement. We will, of course, need the Minister's views, because the regime will be defined in regulations, and any guidance issued by NHS England will, as usual, require the Secretary of State's approval.

The NHS provider selection regime proposal allowed for three scenarios, only one of which leads to a competitive procurement. One allows for the continuation of existing NHS arrangements, and the expectation is that that will be by far the most common route; we certainly hope that is the case. The second allows for a new or changed service to be placed with a provider, without any competitive tendering where there is only one possible viable supplier. The third scenario is the competitive tendering process. As ever, that is where the devil will be in the detail and where there is perhaps a requirement for the Minister to address some well-articulated fears.

Of interest is the proposal that the regime would be bespoke and would sit outside any formal Government procurement rules. Can the Minister confirm that my understanding of that is correct? If it is, perhaps we could call these the Argar accords. It is also contended that the NHS bespoke approach would make it impossible to include the NHS in any trade agreements; at least, that is what is claimed in the NHS document, which does not appear in this Bill. Again, if the Minister can confirm that, that would be welcome.

The old claim was that we could not protect our NHS because of the nasty EU being in the way. Now that we are no longer in the EU, we can have whatever procurement rules we want. If we want the NHS to be the preferred provider, that is fine. However, it is worth noting that Scotland rejected any suggestion that the EU was some kind of obstacle to a bespoke procurement regime a long time ago—the EU appeared to agree, or at least it did nothing to stop Scotland doing what it did. Like so many things that originated from the EU, the rules are quoted in support or against something only when that coincides with a Government position.

We hope that the brave new world that we are in means that the NHS can be protected from trade agreements and rules imposed from outside the country. It also needs to be protected from the Government themselves and the newly emerging fashion for cronyism and the awarding of contracts to friends and family, without proper process. If the NHS is going to award contracts for services funded from the NHS to non-NHS bodies, there will have to be a far more robust system than we the one have at the moment, not a weaker system. The best guarantee of that is enforceable rules, backed by full openness and transparency.

Our approach is straightforward and summarised in a few principles that need to be applied. We hope that this discussion and the amendments will assist the Minister and the Secretary of State in coming up with an eventual regime that works for the public and patients, and not for private interests.

We support the public NHS—an NHS where the services required are predominately provided by the NHS or other public bodies. We believe that any lack of capacity in the NHS to deliver should be addressed by investments, not by short-term cuts and contracts with private providers. There have been various pieces of analysis of the level of private provision in clinical services in the NHS, which some put at around 25%. A better analysis would be of value, and we ask the Minister to commit to undertaking some kind of impact assessment on the level of private provision two years, say, after this Bill becomes an Act—probably just in time for the next reorganisation.

Some think-tanks have urged caution, in that they would not like the NHS to be an monopoly supplier in a manner that curtailed innovation or the spread of best practice. That is a legitimate issue, and there needs to be some consideration, as with the introduction of the wonderful best-value regime 20 years ago, of how best to keep the service under review and to encourage innovation.

We dispute, as others did in 2011, that the private sector somehow has a magic that it brings to the table. Most of our private providers now get their income by supplying the NHS, using NHS staff and working to NHS standards—hopefully at NHS prices. That makes very little sense in terms of where the innovation and magic comes in. The only innovation would be an increase in private investors' profits. So we do not think that is the route we should be going down in terms of provision. We would argue for an increase in NHS capacity, so that there is no need for reliance on the private sector.

Private providers should provide private health care. As we have seen in times of major need, they might also have to assist the NHS with additional capacity. I have sent the Minister many written questions about the private sector assistance provided during the pandemic, but I do not believe—he will correct me if I am wrong—we

have ever got to the bottom of how many procedures were performed on NHS patients by the private sector in that time. As we know, very large contracts were handed out, and it is difficult to see exactly what has been received for them, so we do not know whether value for money was achieved and we cannot ascertain the average cost of each procedure. I am sure the Minister would like to be reassured that best value was achieved. Even if he is not interested in that, the Opposition certainly are. Will he update us on where the investigations are up to on that?

We suggest an approach rather like the preferred provider approach from 2010, where the NHS provides a service unless there is a good reason why that should not be the case. That appears to have caused no problems at all in Scotland or Wales, which went that way many years ago. However, all services should be reviewed so that poor service is not tolerated just because it is publicly provided. Good performance management and early intervention and support should still be the recourse when any public service is beginning to become unsatisfactory. The answer is not to find a private provider to take it over.

This is a simple enough idea. Core NHS services—clinical services and those associated with them—defined in clause 15 should be provided in every area by the NHS itself. They should not be outsourced or privatised. If a service is performing poorly, it should be supported and improved, not sold off to a for-profit alternative that promises the world and delivers very little.

It is important to note that new clause 12 does not provide for goods and services. The NHS does not have to do its own construction, but in-house maintenance and construction might be cheaper than paying someone £200 to change a lightbulb, as we have seen in some of the private finance initiative contracts. The NHS does not have to build its own servers or manufacture its own personal protective equipment, but Northumbria Healthcare NHS Foundation Trust used local businesses to produce PPE. The NHS does not produce drugs, but Colchester has its own production unit for some short-life products. However, we should not let those examples distract us from the core argument about what the NHS should do and what it might do.

Innovation, service redesign and new care pathways should come from within the NHS. The idea of putting out a tender for innovative solutions has failed totally on at least three procurements: cancer and end-of-life care in Staffordshire; the collapse of the £750 million Cambridgeshire older people's services contract eight months into a five-year term, which was also the subject of a National Audit Office report; and, of course, Circle at Hinchingbrooke. That NHS hospital, which had struggled for many years, was run by Circle. It was claimed that that was a great step forward—up to the point when it all went wrong, Circle walked away and the NHS had to step back in. We have had numerous failure regimes that have tried to find ways to improve NHS performance, but none was based on the new logic of collaboration and competition across the patch.

We have also had competition for the whole market. We saw Virgin awarded a 10-year contract to deliver a whole range of community care services in a defined area, which turned supposed competition into another form of monopoly. That was the worst of all words, and that is where change is vital. If the NHS cannot outperform Virgin Care over any period of time—let alone 10 years—something is very wrong and needs fixing. That might be through investment, better management or more intelligent commissioning, but that must be the preferred approach.

We have also seen the wholesale outsourcing of services to the likes of Serco and Group 4 in areas such as ambulance patient transport and a lot of cleaning, catering and cooking. Again, the *Health Service Journal* has many stories about what goes wrong there, such as the Coperforma contract for an ambulance service based in a barn that failed to get its patients to critical appointments. We need to see an end to the dodgy subcontractors that undermine proper scrutiny and decent terms and conditions.

The preferred provider is therefore the right approach. It does not rule out alternative providers; it just says what our preferred solution is. That does not mean a free pass in all NHS trusts for all services—they should always be under appropriate performance management and review—but occasionally a provider may wish to exit from some service. Equally, commissioners who channel the money to the trusts have to monitor delivery against requirements and will flag up early any concerns.

Where a service cannot be provided by a public body because the capability or capacity is not there, or could not be available soon enough, there has to be an option to go beyond the NHS itself—it may also be that an existing NHS provider has been shown to be unable, despite support, to provide what is needed. That has always been the case and some services have been provided by the private sector, for well-established reasons.

3 pm

We should give proper consideration here to the huge contribution made to the NHS by the many small, and a couple of larger, voluntary and social enterprise organisations. We would like to see in the new regime an explicit statement about the value of the third sector. There should be a specific process that allows not just for grant funding of the voluntary and social enterprise partnerships, below some sensible threshold, without any complex onerous requirements being applied.

If a contract was to be awarded to a third sector organisation—again, below a sensible threshold—that could be done without full competitive tendering. When we get to larger-value contracts, we are then dealing with large third sector bodies and they cannot be exempted from proper scrutiny and should not be treated differently from a private organisation, except in so far as social value can be part of the assessment of the bid. Does the Minister accept that there is an argument for some special consideration and possible encouragement for the third sector?

More generally, if a proposed service has some features that require a provider other than the NHS, it is possible that only one provider can meet the requirements and so a competitive process is pointless. If this route is decided uon, the commissioner involved has to publish the evidence that justifies the decision. But again, no competitive tendering would be required or indeed helpful, so some other form of rigour, perhaps with some external scrutiny, ought to be included. So the third way is the one where tendering comes in.

In such cases, there has to be a rigorous regime, at least as good as the public contract regulations—not only to protect the NHS, but to protect bidders from any unfair award. A level playing field should apply to all. Can the Minster confirm for the record that no contract above a reasonable threshold that is to be funded from the NHS will be awarded to any non-NHS body without a proper open and transparent process, which must include publishing the proposal to do this and allowing for representations about the intention?

What we absolutely cannot have is anything like the suggestion being made by, among others, the British Medical Association: that contracts will be awarded without process, as we seen in the past 18 months. In this case, a full competitive tendering process should be used that is at least as robust and fair as the public contracts regulations. The only thing that needs to go beyond that is more clarity about openness and transparency. We start from the principle that everything is in the public domain; if a provider does not like that requirement, it is free not to bid for the contract.

On the actual tender evaluation process, the rigour of the public contract regulations is invaluable. The criteria for awards that used to be the most economically advantageous had a lot going for them, so long as the economic value had the wider context and social values intertwined. Does the Minister agree that more thought needs to go into the provider selection regime to allow for better decision making?

All aspects of provider selection, as well as provider performance management, should be open and transparent and not subject to any commercially confidential opt-outs. Well-established rules about what could be disclosed and when in any contracting are usually ignored by secretive NHS organisations, as we have found on various occasions in the past few years. It is also noted that the proposals in the Bill only refer to "clinical" services; we wish to see various scope extensions. Sara Gorton of Unison talked in her evidence about

> "how important the whole-team—the one-team—approach had been during the pandemic and how crucial that had been to tackling the spread of the virus and the work that the NHS had done. We think that principle should be extended and placed in the provider selection regime as well." —[*Official Report, Health and Care Public Bill Committee*, 9 September 2021; c. 89, Q113.]

That does leave us with the "any qualified provider" strand of procurement to consider, which has been applied to many out-of-hospital services. It is assumed that these are or could be in scope, but we hope the Minister will provide clarity when he responds. Will "any qualified provider" still apply and how does it fit into and sit alongside the new provider selection regime?

One major requirement from us is extending the scope further than the Bill to include those services such as cleaning, catering and portering, which are often referred to as soft facilities management and not classed as clinical, but which have a significant impact on patient experience. We often forget that without the porters, the cleaners and the caterers, none of the frontline patient experience is really possible. They are as much NHS heroes as the doctors, nurses and paramedics. Sadly, that is not always recognised. One of the less commendable NHS activities in recent years has been the attempt to outsource non-clinical services, usually for tax advantages. We support the one-team approach referred to by Unison, not the fragmentation and denigration of parts of the team. Will the Minister be positively inclined to include those services in regulations?

We should also be careful about packaging up services into a product that forces a tendering process because it is not clinical. Does the Minister agree that a service that includes any clinical elements must be regarded as in scope? As I understand it, there is a danger at the moment that a contract that was in fact 95% clinical could still be covered on the basis that only 5% of it was non-clinical. That certainly would not be in keeping with the spirit of what we think the Bill should try to achieve. If we cannot persuade the Minister to extend the scope to cover non-clinical services, there ought to be at least some protection for NHS staff.

We have seen numerous examples over the last decade of back office or other non-clinical services being outsourced. Trusts that do that sometimes refuse to disclose their business case and fail to honour the requirement for a level playing field by excluding the staff from making their own bids to deliver the services, and also by excluding solutions such as shared services. That is an abuse of the proper procurement process and is a loophole that should be closed, even if the basic problem is not addressed. Will the Minister agree that NHS procurements outside the scope of the bespoke provider selection regime ought to also be looked at? In any event, it begs the question of how services out of scope will be dealt with. It would be useful to hear from the Minister about what assessment he has made of how many services would be considered out of scope in the Bill.

Finally, the scope should be extended to cover any contracts procured by the Department itself. I do not want to add to the Minister's workload. If he had accepted our arguments, that would have been achieved. The standards on procurement need to apply across the board. Because the Department's recent record is poor, that needs tackling as well. I will not repeat the arguments about that, but does the Minister accept that a standard should apply to the Department, too? Can he tell us exactly what regime covers the Department and its procurement?

Our proposed new clause 12 makes it absolutely explicit that the NHS is the preferred provider. Amendment 96 also confirms that and sets what we consider to be an essential de minimis requirement for the process, as well as requiring NHS England and each ICB to report each year on the proportion of contracts issued to each different type of provider, together with a plan every three years on how they intend to reduce reliance on private providers and therefore increase NHS capacity. Finally, paragraph (d) of amendment 96 also requires ICBs to be totally transparent about the awarding of such contracts. We think those are the minimum requirements and essential ingredients moving forward.

I end with Dr Chaand Nagpaul's evidence to the Committee on why this matter is important. He said:

> "Just repealing section 75 without complementing it with the right tools to ensure collaboration will not work. In fact, the current arrangements repeal section 75 but do not provide any safeguards, or rather structural processes, that will, in our view, allow the NHS to work as a collaborative system.
>
> "The example I will give is that we believe the NHS should be the preferred provider of care wherever it is capable and wherever it is available to do so. There is so much evidence. People say:

'Does it matter who provides?' Well, it does matter, and all the evidence in the last few years has shown repeated examples. Some of you will remember Circle taking over Hinchingbrooke Hospital. It is very easy for the private sector to say: 'You know what? We will really run the NHS efficiently. We will use all the market skills we have.' The NHS does not work like that."

He also said:

"We forget at our peril the added value, the accountability, the loyalty and the good will that the NHS provides. We really do.

We only have to look back at the last year. Compare the vaccination programme run by the NHS and delivered by NHS staff to Test and Trace. Even with Test and Trace, compare the £400 million that Public Health England had to the billions that went to the private sector, and local public health teams reached 97% of contacts compared to 60% for the others. I am saying that it does matter. Your local acute trust is not there on a 10-year contract, willing to walk away after two years. It is there for your population; it cannot walk away. I think that given those things, we need to make sure the NHS is the preferred provider."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 90, Q113.]

A little later, he added that

"the rules at the moment do not factor in that the NHS provides, in addition to the service, a complete, full body of care for patients. The same money would go on a hip replacement in the private sector. Secondly, there is the training element that I mentioned earlier. Thirdly, no acute NHS trust can walk away after two years—it is there to provide care to its population—but Serco was able to walk away after two years. We have many examples of private companies that have ended their GP contracts. Serco left an out-of-hours contract in Cornwall; that does not happen in the NHS. My local hospital has been there for as long as I can remember—it cannot walk away. The NHS provides accountability and duty, but more importantly, it is actually cost-effective. The staff have national terms and conditions; they provide huge amounts of good will and work above their contracts. It just makes sense to be resourcing our NHS. Every time you take a contract away from the NHS, it is defunding the local system."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 98-9, Q136.]

That is quite a long quote, but it is an important one because it encapsulates perfectly what we are trying to achieve with these amendments and the new clause.

Karin Smyth: I thank my hon. Friend for a fantastically thorough, comprehensive and damming indictment on everything that has come before and for some warnings about what may face us. I rise because I do not want to let the moment go without saying goodbye to section 75. It is what brought me into Parliament, having worked collaboratively in the local system at that time developing clinical commissioning. There was broad agreement before the 2010 election on the direction of travel, which was completely upturned by the coalition Government and the fault lies at the doors of both parties.

The destruction is a warning, though. I am looking around the room, Mr McCabe; I think that nobody on this Bill Committee was a Member of Parliament at that time, apart from your good self. I may be wrong about that, but it might be the case. What I experienced working in that service was the horror that Parliament could produce something that had been so widely warned about and that would be so disastrous. There was not a single ounce of support beyond the political agreement that the coalition formed at that time, which got them into this terrible position, even with the pause, that could not be rowed back. That is something that has helped me as a parliamentarian: what we do here—how we are sometimes invited to vote by the Whips, the scrutiny we give to legislation and the judgment we have to use as individuals—is really important.

Every time we go into the voting Lobby or review legislation, we should all give serious thought to the processes in this place—I understand them now, but did not then—that led to that terrible legislation being passed. We should find better ways to climb off the perch when something has gone as far, and as disastrously, as that legislation did.

There is debate about political interference or accountability—whatever we call it—when it comes to the NHS; as I have said before, the huge amounts of money that parts of the public sector now consume means we should operationalise quite a lot of that. We have heard a lot of that from the Minister over the course of this Bill.

Ultimately, what we have been asked to do is get rid of something we can all agree to get rid of. However, as my hon. Friend the Member for Ellesmere Port and Neston said, we have little idea of what will replace it, and crucially—the theme we keep coming back to: how are the patient and public voice empowered in the new system and how is the local external scrutiny and accountability in the new system? Again, I refer the Minister to my helpful amendment about a good governance commission.

However, the situation does not bode well because, as the pandemic has shown us, when backs are against the wall contracts can be put forward, friends and family can be added to major bodies, and organisations that play by the rules and go through due process can be completely marginalised. That has tainted the Government and all of us as politicians, and we need to get away from it.

Finally, the disaster of the reforms—the Lansley Act—was not only about the public waste, time and opportunity devoted to them; the warnings about pandemics were there at the same time, in 2010 and 2011 reports. The system was not developed and not focused on to how to prepare for the pandemic that we have now endured. That is the cost of management time and focus that was put into this sort of outsourcing, regulations and procurement, and trying to understand them. It was not focused on patient outcomes as they presented or on futureproofing the system. That is why we were not prepared.

We can all dance on the grave of the Lansley reforms today, with this Bill, which is a good thing. However, I am afraid that there is deep concern about what follows. Those reforms should be a lesson to all of us about the consequences of the very grave decisions that we make in this place.

3.15 pm

Jo Gideon (Stoke-on-Trent Central) (Con): I have listened with great interest to the points made by the hon. Lady and by the shadow Minister, the hon. Member for Ellesmere Port and Neston, but I do not recognise my NHS as being a sort of binary choice between public and private sectors.

During the pandemic, we have seen the incredible work across sectors; I am glad that the shadow Minister mentioned the voluntary and community sector, and charities, because that sector has largely been left out of

people's comments. Possibly it was convenient to leave it out because it shows that the breadth of the NHS family is more than the NHS itself; it is very much about everybody working together. For me, that is what integrated care is all about. I welcome the mention of the voluntary and community sector.

When we look at NHS procurement, we also need to focus on prevention as well as on clinical treatments because the wording of new clause 12 seems to focus very much on clinical treatments. We all agree, I think, that the purpose of integrated care is to have a big focus on the prevention piece, and the NHS family must surely include the third sector and private sector providers that are specialists in that area. For me, there is no conflict.

Edward Argar: I welcome the sentiments underpinning some of Opposition Members' comments about our changes to section 75. I am nothing if not prepared to listen and be pragmatic, and I am glad that they at least welcome that aspect of the Bill.

I will address directly a number of Opposition Members' points. My right hon. Friend—I mean my hon. Friend the Member for Stoke-on-Trent Central, but it is surely only a matter of time before she is right honourable—was absolutely right about the NHS family being wider than the NHS itself. All these organisations are involved; to be fair to the shadow Minister, the hon. Member for Ellesmere Port and Neston, he mentioned the voluntary sector and particular organisations that have done amazing work in the past year and a half. In fact, they do that work every year, and day in and day out, working hand in hand with the NHS. I put on the record my appreciation of the independent sector providers for what they have done during this pandemic to support the pandemic response.

The shadow Minister asked a very specific question about what activity had been undertaken, what money had been spent and what assessments had been made, including of value for money. I do not know whether I have written to him already, but a number of colleagues from across the House have written to me and I have set out, in broad terms, the number of patient episodes that have been provided by the independent sector. If he would like me to write to him in a similar vein, I am very happy to do so; my officials have heard that commitment and I will adhere to it. Regarding the broader point that he made about value for money, cost and how money has been spent, those details will be published later in the year in the usual way, when the accounts for the last year have been audited. They will be published; I make that commitment to him.

The shadow Minister raised a number of other specific issues and I will address one head-on before addressing the substance of the amendments. Essentially, he said that the NHS should be deemed the preferred provider by default almost, citing the words of Dr Chaand Nagpaul. Dr Nagpaul and I have our differences of opinion, shall I say, but he is an eminent clinician and performs a very important role, and I put on the record my respect for him and for the principles that he articulates on many occasions.

I believe that the key defining feature should be what delivers the best outcomes for patients, rather than simply having a default presumption. Now, that may well regularly be, as Dr Nagpaul asserted, the NHS. However, I think we should start from the presumption of what delivers the best services and the best outcomes for patients.

The shadow Minister asked—I think he asked this, but if it was the hon. Member for Bristol South I hope she can forgive me—what regime would apply to the Department. My understanding is that that would continue to be the Public Contract Regulations 2015 in the context of the Department itself. The hon. Member for Ellesmere Port and Neston suggested that in the next couple of years we would do the next reorganisation; I can reassure him that I am not necessarily sticking to the new Labour playbook of 1999, 2001, 2003—doing something almost every two years.

The hon. Gentleman's broader point was about the involvement of private sector providers. He will be aware of this, because he knows his NHS and health history, but one of the key points came in 2004—the first time the then Government opened up clinical services to tendering by the private sector, in that case for out-of-hours services. Again, "any qualified provider" dates back to 2009, under the title "any willing provider", as it then was. It was exactly the same scheme, and all that happened in 2012 was that the name was changed from "any willing" to "any qualified" provider; the scheme was brought in under the Government led by Prime Minister Brown.

Governments of all complexions have amended and changed the clinical regime to recognise that there is a role, as there always has been, for private and voluntary sector providers and, of course, for the NHS at the heart of it. None of that puts at risk a taxpayer-funded NHS that is free at the point of delivery. For the record, I reassure the hon. Gentleman, as he would expect me to, that in the context of trade deals the NHS is not for sale: it never has been, and it never will be.

Turning to the detail of the amendments, amendment 95 would change the scope of the regulation-making powers in this clause. Currently, these will govern the procurement of healthcare services for the purposes of the health service; this amendment would broaden the provision so that it extends to all services required by the health service.

The NHS procures many services, but has specifically asked us to introduce a new, tailored provider selection regime that would replace section 75 and enable it to arrange healthcare services in a more flexible manner and one that fosters integration and collaboration. The NHS has told us that the current competition and procurement rules, particularly the PCR 2015 rules, are not well suited to the way healthcare is arranged in the context of the services the NHS provides. They create barriers to integrating care, disrupt the development of stable collaborations and can cause protracted processes with wasteful legal and administration costs, while adding little value to patients or the taxpayer.

Regarding the hon. Gentleman's specific question, I am afraid the individual costs over the years since 2012 would have been borne at a local systems level, so I suspect that they are not agglomerated together in a national figure. However, I understand his reasons for asking.

When NHS England consulted on the new provider selection regime earlier this year, it suggested specific key criteria to be used in decision making under the regime, tailored towards the effective arrangement and

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delivery of healthcare services. The proposed criteria include integration and collaboration, and that services should protect patient choice and focus on tackling inequalities. Having a power to introduce procurement measures specifically for healthcare services will enable procurement decisions to focus on such tailored criteria, and to create a regime that works best for the health service.

However, it is right that non-healthcare services—cleaning services, administrative services and others—should, and will, still fall under the PCR 2015 and, in future, the new Cabinet Office procurement regime, which is currently being considered. This will ensure that these services are still arranged in a way that continues to add the best value to the healthcare system.

We know there may be cases in which it is essential that a service is procured as part of a healthcare service contract—I think that was one of the hon. Gentleman's points. It is for this reason that we have included the ability for regulations made under this power to include provision in relation to mixed procurements, where other goods and services are procured together with healthcare services.

We are working closely with the Cabinet Office and with stakeholders across the health service to ensure that the regulation of mixed procurements of healthcare and other services works effectively for the appropriate arrangement of healthcare services and for the arrangement of wider public services, with respect to their distinct characteristics. Should the hon. Gentleman wish to write to me and ask me to forward his letter to the Cabinet Office to ensure it is cognisant of his views, I am happy to do that.

Amendments 96 and 99 and new clause 12 in effect make statutory NHS providers and general practitioners the preferred provider of NHS-funded services, but our intention is not quite as rigid as what the hon. Gentleman would wish. As I have said, the vast majority of NHS care has and will continue to be provided by public sector organisations, but successive Governments of all political affiliations have allowed the NHS to commission services from the private and voluntary sector, to improve accessibility and experience for patients, to increase capacity swiftly or to introduce innovation.

It is the strong view not just of this Government but of the NHS that local commissioners are the best people to determine what services a local population needs. The best interests of patients, the taxpayer and the population, rather than dogma or ideology, should guide those decisions, and that is what this Bill aims to deliver. I know that the hon. Gentleman is certainly not dogmatic—he may be ideological, but he is certainly not dogmatic—so I hope he appreciates the sentiment behind that statement.

Amendment 99 would mean that a contract for the provision of healthcare services could not be awarded to a body other than a relevant body as defined in the clause unless a full formal competitive tendering process had been followed. This requirement would need to be set out in the regulations made under proposed new section 12ZB.

Amendment 96 would require that regulations include the power for ICBs to commission services provided by an NHS trust or foundation trust without retendering. Regulations would also need to require an ICB to conduct a public consultation and publish a business case where it wished to put out to competitive tender a service currently provided by an NHS provider for contracts over an agreed value. They would also need to require an assessment to be made of alternative ways of providing a service using NHS providers before a contract with a non-NHS provider were extended or renewed. It would require any procurement regulations to be based on the assumption that the NHS is the preferred provider. Regulations would also need to add a requirement on providers to pay and provide terms and conditions of employment to their staff that are at least in line with those of the NHS.

In addition, the amendment would require NHS England to publish a report on the proportion of contracts subject to the regulations made under the new power that are awarded to different types of providers, and would require both NHS England and ICBs to publish a plan for reducing private providers' provision and increasing the capacity of NHS providers to provide those services. As the shadow Minister set out, it would require ICBs to publish in full bids received for contracts, contracts signed and reports of contract management.

By way of context, the NHS has told us that the current competition and procurement rules are not well suited to the way healthcare is arranged. That is why we are creating a new provider selection regime that provides greater flexibility, reduces bureaucracy on commissioners and providers alike, and reduces the need for competitive tendering where it adds limited or no value. I fear that the amendments would start reimposing a degree of that bureaucracy. The absence of competitive tender processes does not mean an absence of open, transparent and robust decision making. Our proposed new regime is designed to allow transparency, scrutiny and due diligence in decision making, but without all the barriers and limitations associated with running full tender exercises.

NHS England has laid out a series of reasons in its public consultation why competitive tendering may not be suitable in every case. We do recognise the value of competition in particular cases, but this is about introducing an element of greater flexibility, rather than rigidity. NHS England has proposed that, having considered a set of key criteria, the decision-making body may have reasonable grounds for choosing either to continue with the incumbent provider where it is doing a good job and the service is not changing, or alternatively, where the service is changing, of selecting one provider or group of providers or of course holding a competitive tendering process.

Structuring the new provider selection regime around such criteria will ensure that the factors taken into account by commissioners are those relevant to the health service, while still retaining flexibility in the types of provider from which commissioners can commission. Amendment 99 would mean that these regulations go further than the existing rules under the PCR 2015. Those regulations allow for an exception to competitive tendering where competition is absent for technical reasons, but this provision would not allow for that, nor for an exception in relation to a procurement for an extremely urgent case.

Transparency was a keen concern of the hon. Gentleman. Regulations and statutory guidance made under new clause 68 will set out rules to ensure transparency and

scrutiny of decisions to award healthcare contracts under the new provider selection regime. The regulation-making powers specifically allow for the imposition of requirements for the purposes of ensuring transparency and fairness in arranging services, which will allow us to design a regime to ensure open, transparent and robust decision-making, including requiring decision-making bodies to keep records of the rationale for their decisions.

We do not consider it necessary to publish all bids received for contracts or the detailed content of all contracts. Doing so would have the potential to prejudice the commercial interests of the parties involved, including NHS commissioners and providers as well as those bidding.

We consider these amendments to be unnecessary. Indeed, we fear that they might actively undermine what the NHS is telling us it needs from the private selection regime to secure high-quality, safe and good-value services. Therefore, I hope that I might tempt the hon. Members not to press their amendment to a vote. I have a feeling, though, that we might face a Division on it in the near future.

Let me move briefly to the clause 68 stand part debate. The clause inserts a new section, 12ZB, into the National Health Service Act 2006.

The Chair: I think we want to stick with the amendments.

Edward Argar: And then we will discuss clause 68 stand part separately?

The Chair: Yes.

Edward Argar: In that case, I nudge the Opposition to consider withdrawing their amendment, but I may be unsuccessful.

3.30 pm

Justin Madders: I picked up some interesting points. There was, I think, some common ground with the Minister about the mistakes of the past. From the contribution of my hon. Friend the Member for Bristol South, I think we have found one positive aspect of section 75, which is that it brought her to this place. At last, there is something positive to say, because we do not mourn its passing. As she said, at the time, not a single ounce of support existed for those rules outside of the coalition Government, but we will not go over all the old ground again.

In his response, the Minister talked about the "any qualified provider" regime that was introduced in 2009. My understanding is that, had we been successful at the 2010 election, we would have moved to "a preferred provider", but, of course, when we look at the commitments made in 2010, we can forget David Cameron's promise not to reorganise the NHS. We will see whether the Minister's promises in respect of that are as robust.

The Minister says that what matters is the best outcome for patients, and we absolutely agree with that. We think that the best outcome for patients will be stability and a regime in which the NHS is the preferred provider, because all the evidence points to better outcomes for patients.

I am grateful to the Minister for not characterising me as dogmatic, because I do not wish to be. I wish to be pragmatic. The idea of putting into the Bill some requirements about what we expect from the regulations is a perfectly reasonable position to take, but until we see those regulations, we cannot be sure about what they will include. By supporting the amendment, what we hope to include is a base position that injects a degree of transparency, which is what has been lacking over the past 18 months, and the Bill clearly fails to refer to any particular issues in that regard. Our view is that the purpose of this Bill should be to reinforce the NHS—to bolster it—by using a preferred provider, which is why we wish to put our amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 8.

Division No. 15]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Davies, Dr James
Bhatti, Saqib	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	Robinson, Mary

Question accordingly negatived.

Amendment proposed: 99, in clause 68, page 61, line 35, at end insert—

"(1A) The regulations must provide that no contract for the provision of the services specified in subsection (1)(a) and subsection (1)(b) may be awarded other than to a relevant authority unless a formal competitive tendering process provided for by the regulations has been followed."—*(Justin Madders.)*

The Committee divided: Ayes 4, Noes 8.

Division No. 16]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Davies, Dr James
Bhatti, Saqib	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	Robinson, Mary

Question accordingly negatived.

Amendment proposed: 96, in clause 68, page 62, line 1, at end insert—

"(3A) The regulations must—

(a) include the power for integrated care boards to continue to commission the services provided by an NHS trust or Foundation Trust without any requirement for any re-tendering process,

(b) require that, prior to commencing any formal procurement process for a service provided by an NHS provider, where the contract value exceeds a threshold set by the relevant integrated care partnership, the integrated care board must conduct a public consultation and publish the business case for opening the service to a competitive tender process,

(c) require an assessment to be made of alternative ways of providing a service using NHS providers before a contract with a non-NHS provider may be extended or renewed,

(d) be based on the assumption that the NHS is the preferred provider of services, and

(e) require providers to pay staff in line with NHS rates of pay and to provide terms and conditions of employment at least equivalent to NHS terms and conditions.

(3B) NHS England must publish a report each year on the proportion of contracts subject to the regulations which are awarded to each of NHS, third sector, local authority and independent sector providers.

(3C) NHS England and each integrated care board must publish a plan every three years on reducing the provision of NHS services by private providers and increasing the capacity of NHS providers to provide those services.

(3D) Integrated care boards must publish, in full and without any recourse to commercial confidentiality, all—

(a) bids received for contracts,

(b) contracts signed, and

(c) reports of routine contract management."—*(Justin Madders.)*

The Committee divided: Ayes 4, Noes 8.

Division No. 17]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Davies, Dr James
Bhatti, Saqib	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	Robinson, Mary

Question accordingly negatived.

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

Edward Argar: I will be brief because we covered key aspects of clause 68 in debates on the amendments. The clause inserts proposed new section 12ZB into the NHS Act 2006. Section 12ZB allows the Secretary of State to make regulations setting out the regulatory framework for the procurement of healthcare services, to better meet the needs of the NHS.

Section 12ZB provides further information about the content of those regulations. They may contain provision in relation to the objectives of procurement, and they may contain provisions ensuring transparency, fairness and effective management of conflicts of interest, as well as provision for the purpose of verifying compliance with the regime. The new section also allows for NHS England to publish guidance about compliance with the new procurement requirements to which relevant authorities, as defined in the section, must have regard.

The NHS has sent us a clear message that the current regime for arranging healthcare services is not working. It is confusing, overly bureaucratic and does not fully support the integration and efficient arrangement of services and collaboration in the best interest of patients, which, of course, run through the Bill like a golden thread. Through the clause, we will develop a new provider selection regime for the NHS and public health—a bespoke NHS regime that will give the NHS and local government more discretion over how they arrange healthcare services. Informed by the consultation run by NHS England earlier this year, it will aim to enable collaboration and collective decision-making—recognising that competition is not the only way of driving service improvement. It will aim to reduce bureaucracy on commissioners and providers alike, and to remove the need for competitive tendering where it adds limited or no value.

We recognise that in many cases competition can be beneficial for procurement. Where a competitive tender is the best way for an NHS commissioning body to secure value and quality in its healthcare provision, it will be used. However, it will no longer be the default that contracts in the NHS are automatically put out to tender. All decisions about provider selection will continue to be made in an open and transparent way, considering key criteria and applying them to decision making, in the best interests of patients and the taxpayer. I commend the clause to the Committee.

Justin Madders: I will not repeat all my comments from earlier, to save the Committee's time. I have two remaining specific questions, which I hope the Minister can address. The clause says that regulations "may" be produced. Can he state for the record that there will be regulations? Can he also give us some indication of when they are likely to be made and when they are likely to take effect?

Edward Argar: I can reassure the hon. Gentleman that "may" is the technical language used in drafting such legislation, but we intend that they will be made. I am afraid I will disappoint him on the second part of his question, because I would not presume to say exactly when; that will be down to the passage of this legislation and then the usual wait and the discussions through the usual channels on securing an appropriate slot for the regulations. I hope I have given the hon. Gentleman a modicum of reassurance.

Question put and agreed to.

Clause 68 accordingly ordered to stand part of the Bill.

Clause 69

Procurement and patient choice: consequential amendments etc

Justin Madders: I beg to move amendment 97, in clause 69, page 62, line 26, at end insert—

"(1A) In the National Health Service Act 2006, in section 272(6), after paragraph (za), insert the following paragraph—

'(zaa) regulations under section 12ZB,'".

This amendment would require a draft of procurement regulations under new section 12ZB of the National Health Service Act (inserted by clause 68) to be laid before, and subject to approval by resolution of, each House of Parliament.

I will not detain the Committee long on this amendment. Following on neatly from our previous discussion, it requires that the regulations, which I am now assured

will be produced, are subject to a resolution of approval by both Houses. I do enjoy spending time in Delegated Legislation Committees with the Minister, and I hope we will be able to do that again as a result of this amendment's being accepted.

Edward Argar: I am, as ever, grateful to the hon. Gentleman. The amendment would require a draft of procurement regulations under new section 12ZB of the National Health Service Act to be laid before, and subject to approval by resolution of, each House of Parliament. As set out in our delegated powers memorandum, the powers created by clause 68 amend the NHS Act 2006. In line with the vast majority of regulations made under that Act, these powers will be subject to the negative procedure in section 272(4) of that Act.

As demonstrated by the passage of the Health and Social Care Act 2012, there is significant parliamentary interest, both in this House and the other place, in the rules for determining how healthcare services are arranged. However, it is vital that we strike the right balance between democratic scrutiny and operational flexibility. The negative procedure provides that balance, ensuring transparency and scrutiny, while also providing sufficient flexibility to ensure that the regulations continue to drive high-quality services and value for money.

We have consulted extensively on the proposals for these regulations to ensure that we are delivering the flexibility, transparency and integrated approach that the NHS has asked for. The engagement exercise undertaken in early 2019 collected views from across the health sector, and the proposals put forward by NHS England around procurement gained widespread support, with 79% of respondents agreeing or strongly agreeing with the proposals.

Earlier this year NHS England consulted on further detail of the proposed regime that should apply when healthcare services are arranged in future, following removal of the current requirements. NHS England received a range of responses from NHS national and representative bodies. In addition to written feedback, it met NHS colleagues and external stakeholders. We have been and continue to be as transparent as possible in our approach to these proposals. Therefore, I suggest that the hon. Gentleman amendment's is unnecessary.

Justin Madders: In the light of the Minister's comments, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

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

Edward Argar: I will be very brief. The clause will remove the specific healthcare procurement rules that currently apply to NHS commissioners when arranging clinical healthcare services. Specifically, it will repeal sections 75 to 78 and schedule 9 to the Health and Social Care Act 2012 and revoke the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. It also makes other minor, consequential amendments in relation to these changes and the introduction of the power to make a new provider selection regime for procurement of healthcare services under clause 68.

3.45 pm

The NHS has told us that it is wasting precious resources on unnecessary tendering processes. It has told us of the frustration about the time and bureaucracy involved in procuring services or infrastructure. Therefore, we believe it is crucial to replace those processes with a new, more flexible system, to ensure that competitive tendering takes places only where it is in the best interests of patients and the taxpayer. Without this clause, the existing procurement processes would continue to apply to the NHS.

Question put and agreed to.

Clause 69 accordingly ordered to stand part of the Bill.

Clause 70

DUTY TO PROVIDE ASSISTANCE TO THE CMA

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

The Chair: With this it will be convenient to discuss the following:

Clauses 71 and 72 stand part.

That schedule 12 be the Twelfth schedule to the Bill.

Clause 73 stand part.

Edward Argar: I will try to be as brief as I can, while giving the Committee the information it wishes to have.

This package of measures is aimed at promoting collaboration in the NHS, reflecting a shift towards integration between commissioners, providers and other partners as a way of improving the healthcare people receive. Clause 70 allows for the removal of Monitor and the Competition and Markets Authority's duties to co-operate in the exercise of their functions as concurrent competition regulators. Instead, they are replaced with a duty on NHS England to share regulatory information with, and provide assistance to, the CMA where the CMA requires it to exercise its functions.

Clause 71 removes the Competition and Markets Authority's role in reviewing mergers solely involving NHS foundation trusts, NHS trusts or a combination of both. The CMA has led a number of investigations into NHS provider mergers or acquisitions in recent years. Although it has approved all but one merger, the investigations have been costly and time-consuming for the organisations involved.

We recognise the CMA's important role in investigating alleged infringements of competition law and particular markets if it sees issues for consumers with reducing competition. However, as has been alluded to, the NHS is not a true market, and it has become clear that the CMA is not the right body to review NHS mergers. Instead, NHS England will continue to review all NHS provider mergers to ensure they have clear benefits for patients and the taxpayer. The CMA will retain its merger control powers in relation to the private healthcare and pharmaceutical industries, where competition plays a greater role. The NHS should be able to make decisions about provider mergers itself. Without this clause, NHS provider mergers will still be subject to costly, time-consuming investigations.

Building on the experience of the last few years, the Bill will clarify the central role of collaboration in driving performance and quality in the system. As part of that, under clause 72, we are looking to remove

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Monitor's role as a concurrent competition regulator. However, although we are removing Monitor's competition regulation functions, it is right that NHS England should continue to share regulatory information with and provide assistance to the CMA so that the CMA can carry out its functions. The clause will ensure that the CMA has the information and assistance it needs to do that in respect of its competition functions to prevent anti-competitive behaviour in the wider sector. That will ensure that the CMA can continue to make sure that the healthcare sector works for consumers, patients and the taxpayer.

The clause removes Monitor's competition functions, which it exercises concurrently with the CMA. It also inserts schedule 12, which makes consequential amendments in relation to the removal of Monitor's competition functions. The Health and Social Care Act 2012 allowed Monitor to exercise some of the functions that the CMA holds under the Competition Act 1998 and the Enterprise Act 2002, but solely in relation to the provision of healthcare services in England. Those included powers to take action on anti-competitive agreements and conduct in the sector and powers in relation to mergers in the sector.

The Bill will enhance collaboration between different NHS commissioners, providers and local authorities. We therefore expect that NHS England's primary role, following its merger with Monitor, will be to support commissioners and providers to deliver safe, effective and efficient care, rather than to act as an economic or competition regulator.

While competition will continue to play an important role, including through patient choice and the new provider selection regime, it is right that the duties and role of the merged NHS England give greater weight to fostering collaboration and integration rather than enforcing competition, and that competition regulation is left to the CMA. The concurrent competition duties and functions of Monitor should therefore be removed. Schedule 12, inserted by clause 72, makes the necessary consequential amendments to take account of the removal of Monitor's competition functions. The clause allows NHS England to work collaboratively with organisations to deliver the best possible services to patients.

Finally, clause 73 removes the CMA's role in reviewing contested licence conditions. The licence conditions have not changed substantially since they were first agreed in 2013. However, NHS England and NHS Improvement's oversight of the NHS has changed significantly. Their primary role is to support the delivery of safe, efficient and effective care. The merged NHS England, as provided for under this Bill, should be able to set its own licence conditions for providers and regulate providers of NHS services without needing to refer matters to an external competition regulator such as the CMA.

NHS England will remain under duties to consult with local organisations on revised licence conditions. That, alongside the removal of the CMA's review functions, ensures that any decisions remain in the interests of the NHS as a whole. In addition, NHS England's accountability arrangements to the Secretary of State and Parliament offer a further safeguard against disproportionate changes to licence conditions. Sufficient safeguards, such as those that I have mentioned, ensure that providers have input into any proposed changes, without the need for oversight from a third party.

We therefore believe that these measures deliver the changes that the NHS has been asking for to help it deliver the long-term plan and recover from the pandemic. I therefore commend them to the Committee.

Justin Madders: I will not detain the Committee long, but perhaps we need a minute to pause, because, as my hon. Friend the Member for Bristol South said on Tuesday, this marks the end of an era. Monitor is gone, competition is no more, and procurement is gone—I think—and become bespoke, to be determined in more detail in the regulations. Perhaps even more stark is the fact that ICBs now have providers on the board, having jettisoned the GPs, and that NHS England is now both an actual commissioner and a systems manager for both commissioners and providers. It feels like we are going back to the future.

As the Minister said, these clauses end the role of the Competition and Markets Authority. This is the final nail; it is perhaps the final recognition that the wild promises made about the 2012 Act have failed to achieve what they said they would. The expectations that Lansley set out back then have failed to produce any desirable results. I do not know whether Government Members wish to shed a tear at this point for the end of these measures, but, for Opposition Members, health is not a commodity; it is a right. Health is not a product, and the NHS is not—and never can be—a market.

As we see the end of the ideological attempt to create a market, Opposition Members cheer the bidding into history of this failed experiment, which should never have occurred. Turning to the actual substance of the clauses, as the Minister set out, they do what is necessary to achieve that aim.

Question put and agreed to.

Clause 70 accordingly ordered to stand part of the Bill.

Clauses 71 and 72 ordered to stand part of the Bill.

Schedule 12 agreed to.

Clause 73 ordered to stand part of the Bill.

Clause 74

Special Health Authorities: removal of 3 year limit

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

The Chair: With this it will be convenient to discuss clauses 75 and 76 stand part.

Edward Argar: Clauses 74, 75 and 76 repeal the three-year time limit on special health authorities, restate the requirements for special health authorities and NHS trusts to keep proper accounts and records, and repeal the powers of the Secretary of State to make a property or staff transfer scheme.

Together, along with the provisions in the Bill to merge NHS England and NHS Improvement and the powers we will discuss in part 3 of the Bill in a few weeks' time, these technical changes will help ensure

that we have flexibility in the arm's length body landscape to support the delivery of a world-class healthcare system.

Clause 74 repeals legislative provisions that currently impose a three-year time limit on any newly established special health authority. When the three-year time limit was initially imposed under the Health and Social Care Act 2012, it was envisaged that any future special health authority would have time-limited functions and therefore be temporary in nature. This has not proved to be the case.

The NHS Counter Fraud Authority is the only special health authority created since the time limit was introduced. The Government consider it unnecessary for the NHS Counter Fraud Authority, or any other special health authorities that are established in future, to undergo the process of extending their lifespan every three years. As well as repealing the time limit, the clause sets out changes to the statutory instrument used to create the NHS Counter Fraud Authority, to reflect the fact that there is no longer an abolition date.

Clause 75 simply tidies up provisions in the current legislation in respect of requirements to keep accounts. It restates the requirements for special health authorities and NHS trusts to keep proper accounts and records. It also restates a number of requirements in relation to the auditing and publication of accounts. This clause does not create any change in existing arrangements.

Finally, clause 76 abolishes powers taken in the Health and Social Care Act 2012 to transfer property, rights and liabilities from bodies abolished or modified by that Act. Those powers are now spent, so we are removing the clause to ensure neatness of the statute book, especially as a number of bodies in the 2012 Act are being abolished by this Bill. However, we have retained the ability to make transfer schemes in respect of previously transferred property and rights.

The Bill allows property, rights and liabilities that have been transferred previously under section 300(1), to subsequently be transferred to a Minister of the Crown, NHS England, an integrated care board, an NHS trust or foundation trust, or a qualifying company. That will ensure clarity that rights, property and liabilities are properly allocated and maintained, and not lost to the NHS.

These technical changes will support the wider intentions of the Bill to have a flexible and responsive national architecture for managing the healthcare system. I therefore propose that these clauses stand part of the Bill.

Justin Madders: I will not detain the Committee for long. We are enjoying the Minister's conversion as regards the folly of the 2012 Act, this being another example of things not turning out as originally envisaged. As he said, these clauses are necessary and we will not oppose them.

Question put and agreed to.

Clause 74 accordingly ordered to stand part of the Bill.

Clauses 75 and 76 ordered to stand part of the Bill.

Clause 77

Abolition of Local Education and Training Boards

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

Edward Argar: Clause 77 is a relatively short clause, which seeks the abolition of local education and training boards—these committees of Health Education England will, by the provisions of the clause, be abolished. In consequence, as set out in the legislation, we amend the Care Act 2014 to reflect this abolition. This is a substantive provision, but it is of a technical nature, to reflect the evolution of the provider landscape. I propose to make no further comments at this stage, but I suspect the shadow Minister may wish me to respond.

4 pm

Justin Madders: I have a couple of questions for the Minister. We would more accurately describe this as a reflection of the reality on the ground, and how local education and training boards have not really been the vehicle for change that they might have been. Their original rationale was to

"build a system that is responsive to the needs of employers, the public and the service at local level."

It seems odd that this is happening, given that the thrust of the rest of the Bill is to increase local autonomy, but I understand that the regional people boards will be taking up the majority of the slack. It raises the question of how exactly the undoubted variation in recruitment and training needs within ICBs and regions will be addressed, and how ICBs will interact. I would like to hear from the Minister about that. There is also a concern from the British Medical Association that this could mean the loss of dedicated local support systems for GP trainees, and there is some need for clarity on how that function will be met.

Edward Argar: The shadow Minister is right in surmising that once LETBs are abolished, their functions will be discharged by HEE directly in the manner he has set out. On his specific questions, HEE will continue to have responsibility for workforce planning and will engage with regional people boards, integrated care boards and the regional directorates of NHS England to carry out this function. Those responsibilities will be set out in a report that we will publish describing the system for assessing and meeting the workforce needs of the health service in England, as debated in relation to clause 33—to which we may yet return, either on the Floor of the House or in the other place.

We are not removing local or regional workforce planning from the statute, as the hon. Gentleman suggested; HEE will continue to have responsibility for that workforce planning. The LETBs were sub-committees of HEE and reported to the HEE board in any case, so clause 77 just removes some of the rigidity in respect of how HEE had to operate. As is the theme throughout this legislation, this clause seeks to give a greater degree of flexibility and permissiveness to allow the system to adapt to changing needs. On that basis, I ask that it stand part of the Bill.

Question put and agreed to.

Clause 77 accordingly ordered to stand part of the Bill.

Clause 78

Hospital patients with care and support needs: repeals etc

Alex Norris: I beg to move amendment 98, page 68, line 22, at end insert—

[Alex Norris]

"(2A) A social care needs assessment must be carried out by the relevant local authority before a patient is discharged from hospital or within 2 weeks of the date of discharge.

(2B) Each integrated care board must agree with all relevant local authorities the process to apply for social care needs assessment in hospital or after discharge, including reporting on any failures to complete required assessments within the required time and any remedies or penalties that would apply in such cases.

(2C) Each integrated care board must ensure that—

(a) arrangements made for the discharge of any patient without a relevant social care assessment are made with due regard to the care needs and welfare of the patient, and

(b) the additional costs borne by a local authority in caring for a patient whilst carrying out social care needs assessments after a patient has been discharged are met in full.

(2D) The Secretary of State must publish an annual report on the effectiveness of assessment of social care needs after hospital discharge, including a figure of how many patients are readmitted within 28 days."

Clause 78 is the final clause of part 1, but it is an important one, and we hope that the amendment improves it. I will be interested to hear the Minister's views. This all relates to discharge to assess, where patients are discharged from hospital into the community setting and have their care needs assessed at home, or wherever they have gone from hospital, rather than waiting to be discharged from hospital and having to stay there longer than they clinically need to before the assessment takes place. Importantly, this is something that has been trialled during the pandemic. There is a lot of vulnerability at that point, and this process will matter to a lot of people. It is right that we give it proper consideration, and I think we ought to tighten it up.

I will confess that I have gone back and forth on the principle of discharge to assess, and I have had this conversation with colleagues in recent months. When the Bill was published, my first instinct on this clause, as former local authority social care lead, was a negative one. I felt—I still have this lingering doubt—that there was a real risk of patients essentially being parked in the community to the detriment of their health, with the obligation and cost put on local authorities. Of course, in many cases, some of that will be borne by continued healthcare funding. However, in the end that will become a local authority responsibility for each individual, and there will be a significant risk of them being readmitted shortly afterwards.

Local authorities are already scandalously underfunded to meet the social care needs of their population. Adding some of the most vulnerable people to that list and to the quantum of need that needs to be met will add greater risk, so I have serious reservations. This is not a conceptual debate, and that makes life easier; we have evidence to work with. Through no one's planning, we have essentially run a de facto pilot scheme during the pandemic, so we know of what we talk. We have a sense of what is going on on the ground, and clause 78 will put it on a permanent footing.

On matters relating to local government, I always fall back on my former colleagues in local government. Their views on this are very clear, and I have had this conversation with them a lot. It always ends up with me saying, "Are you sure?" However, we should not miss their evidence. They say:

"The repeal of legislation related to delayed discharges is good news. This paves the way for the continuation of discharge arrangements which have worked well during the pandemic. The emerging evidence is that going home straight from hospital is what people want."

I can certainly understand that. They also want greater clarity on the future of this de facto pilot from next month, in the interregnum between when the Bill becomes law and when the funding runs out next month. That is a very reasonable request, and I hope the Minister can respond. The strength of feeling from local government colleagues—our experts by experience—cannot be ignored, and that is why we are seeking to improve rather than prevent this innovation. It does need improving.

Important concerns were raised in the written evidence from Carers UK, which says:

"Under the CC (Delayed Discharges, etc.) Act 2003 a carer's assessment can be requested and if so, a decision must be made about what services need to be provided to the carer, whether by social services or a consideration by the NHS, to ensure that the 'patient is safe to discharge'."

That will be repealed by clause 78. However, they will still be able to fall back on the Care Act 2014, so the carer will get a carer's assessment under that if they wish. Presumably, that will now take place post-discharge. That is quite a significant change. A great deal of people will become family carers overnight. They might not be conscious that that will happen, but before anybody has made any assessment of their capability to do so, they will quickly find themselves operating as family carers for very vulnerable people immediately post discharge. By the time they get the carer's assessment, they may well have been struggling to cope for a significant period of time. That could have some dreadful consequences, which is why amendment 98 states that there must be an assessment within two weeks. Obviously, we would want it much more quickly than that, but two weeks is a bare minimum backstop.

I do not think that this is catastrophising. According to research that Carers UK submitted, 26% of carers had not been consulted about discharge before the discharge of the person they care for, and a third were consulted only at the last minute. I do not think that is setting families up to succeed. If the Minister thinks that that will get better as a result of these innovations, we would welcome that, but I would like to understand why he thinks that might be the case and how the situation will look better. Carers UK recommends putting greater responsibility on the integrated care board to have oversight of how discharge to assess is working for the individuals in their care and across their footprint more generally. That is what we have sought to recommend with amendment 98.

The concerns of Carers UK are echoed by the British Association of Social Workers, and social workers, like family carers, have first-hand experience of the trial. The association worries about there being a move away from the fundamental point that the wellbeing principle is uppermost, and its evidence is concerning:

"A survey of Social Workers conducted in December 2020 involved in hospital discharges highlighted that the vital contribution of social work in the multidisciplinary team was being marginalised by the medicalisation of people's journeys out of hospital. Most importantly, social workers felt that the voice of the individual was lost".

It is quite significant to say not only that skilled staff would not be able to play their normal role in the process but that the individual's voice would not be there.

The worst manifestation of the provisions in the clause would be for it to be in the system's interest to move people out of hospital, because that would then be the priority. We need to make sure that that is not the case. The British Association of Social Workers would rather that the clause was not in the Bill at all, but we have not gone that far and have sought to improve it by putting a maximum two-week wait time in the Bill. That would be prudent. The amendment would also centre the integrated care board in the management and oversight of the process. If the integrated care board is to act as a system leader and integrator, surely such a system process—this is the ultimate system process—that touches on the borders between institutions ought to be within its purview. Otherwise, where will the oversight come from? Who will hold the different parts of the system to account?

I hope that the Minister addresses the concerns I have expressed, because this is an important and, in the plainest-speaking sense, risky decision. There are ways to mitigate that and we have suggested a good one in the amendment. I am keen to hear the Minister reflect on that.

Karin Smyth: I echo the comments of my hon. Friend the Member for Nottingham North. We discussed this when the Bill hit the Vote Office, because from a system management point of view I saw this change as a positive move. It was necessary in the system to increase the flow out of hospitals, particularly in the pandemic.

We talk about flows out of hospitals, but we are really talking about individuals—our nearest and dearest. During the summer, my husband and I were both responsible for supporting my mother and my mother-in-law in and out of the system, and my mother-in-law was part of the discharge to assess programme. This is not the place for me to rehearse the traumas of becoming, as my hon. Friend so eloquently put it, a family carer overnight and realising, if I did not know already, how little there is outside hospital. My hon. Friend's point about families suddenly becoming responsible carers overnight is really important. Thousands and thousands of families are finding themselves in that position. Most people would agree about discharging people out of hospital as soon as possible, particularly given the fear of covid and people not being able to go into hospital to see their loved ones. In my mother's case, she was discharged very quickly, and we went to get her because there was no ambulance service.

The closure of hospitals to visitors adds to the trauma of an acute episode, and people then have to take on that responsibly. People are assessed for care and told in the same sentence, "You're assessed for care, but there is no care," and that care takes several weeks to come into play. Among my own family and my in-laws, we have a clinical person in the team, we are fairly articulate, we are knowledgeable about the system and we perhaps know what we are taking on and have the capacity and capability to manage the situation, but it is deeply worrying that people who have no advocate or no other support—even social workers—are told when they are discharged that they need assessed care but there is none. It will take some time for us to understand what has happened to thousands of people who have found themselves in such a difficult position. I am particularly worried about people who have no advocate.

I suspect that the Minister will not accept the suggestions in the amendment now, but I hope he will take advice so that we can understand better—perhaps through an assessment—what has happened to people who have been discharged in the last few months without having support in place. We need to hear about that.

4.15 pm

Of course, if those people stay in hospital, they get some sort of support and care, and throughout the winter, families will not support the discharge of their loved ones. That is a difficult place to be. I have seen, as we all have, situations in which the safest thing for a person to do is to remain in hospital, even if they do not need acute care. However, that is no place for anyone to be if they do not need such care, and we would not want to get to that place. If the Minister does not accept the amendment, he would be wise to use the recess, before the Bill goes to the other place, to put in greater provisions in this area. If we all accept that moving out of hospital is a good thing, many more safeguards must be put in place to support families who find themselves becoming carers overnight, as well as people who have nobody to care for them.

Edward Argar: I am grateful to the hon. Member for Nottingham North and the hon. Member for Bristol South. I knew that the hon. Member for Nottingham North and I had a shared background in local government, but I did not realise that it may have covered the same portfolio. I share his view on two points in particular. First, we have had the opportunity, of necessity, during the pandemic to see how the approach might work in practice. My instinctive reaction is that I can see how it works from the perspective of the system and the health service but, with my old council hat on, I would say, "How does it work from our perspective?" What we have seen throughout the pandemic has not been without its challenges, but it has broadly worked.

Like the hon. Gentleman, I am always happy to speak to my local councillors, who will not hold back in telling me what they think is working and what is not. However, I do think that this is the right approach when implemented properly. We know that if people stay in hospital longer than is medically necessary, it affects not only the system but individuals' physical and mental health. It is therefore right that we get people home or to an appropriate interim place where they can be cared for and continue their rehabilitation in the right setting.

The amendment would introduce a new requirement for local authorities to carry out social needs assessments either before a patient has left hospital or within two weeks of discharge. Integrated care boards would have to agree the process with local authorities, including any penalties when local authorities fail to assess people within two weeks. It would also introduce a requirement for an annual report to be produced

"on the effectiveness of assessment of social care needs"

post discharge. As I hope I alluded to in my opening remarks, I entirely appreciate the intention of the amendment—all patients must receive the care that

[Edward Argar]

they need on being discharged—and understand where the hon. Gentleman and his colleagues are coming from, but I am not sure that it is the best way to advance that objective.

Existing discharge guidance states that health and social care systems must determine the most appropriate discharge pathway for each person to ensure that they receive the interim care and support they need, pending full assessment. Legislation already requires the NHS to meet people's health needs, and local authorities must still assess and meet people's adult social care needs. We are co-producing new statutory guidance on how the existing statutory duty for health and social care partners to co-operate will apply in relation to discharge. By way of reassurance, where local areas follow the discharge to assess model, unpaid carers are still entitled to a carer's assessment where they are not able to care or need help. A carer's assessment should be undertaken before caring responsibilities begin for a new caring duty or if there are increased care needs.

As all colleagues who have been involved in local government or the NHS will know, the devil is in the implementation rather than the detail in this case. We must ensure that the system works. The entitlement is there, and we must ensure that that pulls through into practical realities. The hon. Gentleman will be aware that the discharge guidance also states:

"Before discharge a determination must be made about the status and views of any carers who provide care, including that they are willing and able to do so."

Evidence broadly suggests that when long-term needs assessments are carried out at the point of optimum recovery, that leads to a more accurate evaluation of needs and more appropriate care packages. Many people discharged from hospital require longer than two weeks to recover; we fear that requiring social care needs assessments to be completed within two weeks of discharge would create an extra layer of bureaucracy. In practical terms, it would not necessarily function in people's best interests.

Our extensive engagement with health and social care partners has highlighted how current bureaucratic discharge requirements, including penalties for local authorities, can damage relationships and create discharge delays, and they do not support collaborative working across sectors. We fear that creating a new penalty for local authorities for failing to carry out assessments would again risk creating a tension within the system, which would go against the spirit of the integrated working that the Bill seeks to support and the good co-operation that I would argue normally and generally occurs. Our existing clause creates freedom for local areas to develop discharge arrangements that best meet their local needs.

I fully appreciate the need for accountability, which is why we are working with NHS England to publish hospital discharge data from 2022 onwards that will include data on the destination and discharge pathways being used to support people after they leave hospital.

For those reasons, I gently encourage the hon. Gentleman to consider not pressing his amendment to a Division.

Alex Norris: I am happy to say that I will consider that request; obviously, I have heard what the Minister has said. I was slightly heartened to hear the point about guidance. I suspect that if we do not see something exactly like what I propose in the amendment, we will see something very similar to it being put in the guidance.

However, we do not have that guidance at this point, which leaves us with two alternatives: either we press the amendment to a Division or we do not. If we do not, we will not be opposing the stand part debate, which means that we might create the impression that we have waved through something that we are concerned is too loosely defined. For that reason, we have to press the amendment to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 8.

Division No. 18]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Davies, Dr James
Bhatti, Saqib	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	Robinson, Mary

Question accordingly negatived.

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

Edward Argar: I will endeavour to be relatively brisk; I think that we have covered some of the issues pertaining to the clause in our discussion of the hon. Gentleman's amendment.

The clause repeals legislative barriers to the discharge to assess model, in order to better align legislation with current best practice. During the pandemic, local authorities and the NHS developed innovative ways to support better discharge from hospital to community care. The clause is crucial in enabling local areas to build on those partnerships to adopt the discharge approach that best meets local needs, including the discharge to assess model.

The clause will enable the safe and timely discharge of people to a familiar environment where possible. Individuals receive recovery and re-enablement support, and are assessed at the point of optimum recovery. This will enable a more accurate evaluation of their long-term care and support needs. The provision does not change existing legal obligations on NHS bodies to meet their local population's health needs, and local authorities are still required to assess and meet people's needs for adult social care.

In addition to those responsibilities, we are co-producing discharge guidance with health and social care partners, setting out how the existing statutory duty in the NHS Act 2006, which requires health and social care partners to co-operate, will apply to discharge. Our guidance will be clear that no one should fall through the gaps so that people receive the right care in the right place at the right time. Discharge to assess will not change the thresholds of eligibility for continuing healthcare—CHC—or support through the Care Act 2014. The clause includes consequential amendments to other pieces of legislation. Those are needed to remove references to pieces of legislation that we are repealing with clause 78 and to tidy up the statute book.

Alex Norris: I shall not duplicate anything I said in the previous debate. I fully support what my hon. Friend the Member for Bristol South said. We accept that hospital is a bad place for a sick person to be once their initial ailment is dealt with. They do not want to be around all sorts of illnesses when they are susceptible.

I want to make a final point on rehabilitation and re-ablement, as the Minister called it. That is at its most valuable as early as possible. Getting a person into their rehab and exercises rather than just being parked in an armchair is a big part of someone's bouncing back from physical injury, and it helps with mental health as well. It is not desirable for them to wait a long time for an assessment because that will be a part of how they bounce back, rebuild their lives, and re-able and rehabilitate themselves. That strengthens rather than weakens the case for trying to be very tight about how quickly we want that to happen.

Edward Argar: I concur with the sentiments that the hon. Gentleman has expressed. It is absolutely right not only to have the right model in place but that that model moves swiftly and effectively to provide the services required.

Question put and agreed to.

Clause 78 accordingly ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. —*(Steve Double.)*

4.26 pm

Adjourned till Tuesday 19 October at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

HCB82 SeeAbility

HCB83 Ealing Reclaim Social Care Action Group (ERSCAG)