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Programme order amended.
Clause 22 as amended, agreed to.
Clauses 23 to 38 and 40 to 43 agreed to.
Schedule 3 agreed to.
Clauses 44 and 47 to 49 agreed to.
Adjourned till Thursday 10 March at Nine o’clock.
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

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Saturday 12 March 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES

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The Committee consisted of the following Members:

Chairs: † Mr Jim Hood, Mr Mike Hancock

† Abrahams, Debbie (Oldham East and Saddleworth) (Lab)
† Barron, Mr Kevin (Rother Valley) (Lab)
† Blenkinsop, Tom (Middlesbrough South and East Cleveland) (Lab)
† Brine, Mr Steve (Winchester) (Con)
† Burns, Mr Simon (Minister of State, Department of Health)
† Burstow, Paul (Minister of State, Department of Health)
† Byles, Dan (North Warwickshire) (Con)
† Crabb, Stephen (Preseli Pembrokeshire) (Con)
† de Bois, Nick (Enfield North) (Con)
† James, Margot (Stourbridge) (Con)
† Kendall, Liz (Leicester West) (Lab)
† Lefroy, Jeremy (Stafford) (Con)
† Morgan, Nicky (Loughborough) (Con)
† Morris, Grahame M. (Easington) (Lab)
† Poulter, Dr Daniel (Central Suffolk and North Ipswich) (Con)
† Pugh, John (Southport) (LD)
† Shannon, Jim (Strangford) (DUP)
† Smith, Owen (Pontypridd) (Lab)
† Soubry, Anna (Broxtowe) (Con)
† Sturdy, Julian (York Outer) (Con)
† Thornberry, Emily (Islington South and Finsbury) (Lab)
† Turner, Karl (Kingston upon Hull East) (Lab)
† Twigg, Derek (Halton) (Lab)
† Wilson, Phil (Sedgefield) (Lab)

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Tuesday 8 March 2011

(Afternoon)

[Mr Jim Hood in the Chair]

Health and Social Care Bill

Clause 22

COMMISSIONING CONSORTIA: GENERAL DUTIES ETC.

Amendment proposed (this day): 94, in clause 22, page 32, line 20, after ‘grant’, insert ‘or loan’.

(Mr Simon Burns.)

4 pm

Question again proposed. That the amendment be made.

Liz Kendall (Leicester West) (Lab): I was asking what difference the Government amendment will make. At the moment, anyone who commissions a service from a voluntary organisation has to go through this process. What will be different as a result of the amendment, and why do the Government wish to make the change?

The Minister of State, Department of Health (Mr Simon Burns): If it helps to have it on the record, I can tell the hon. Lady that the amendment will transfer the power of PCTs to make grants of section 64 money to voluntary organisations to consortia. Under the new architecture, consortia will have that power.

Liz Kendall: I thank the Minister for that clarification. When I ran a voluntary organisation, I had some experience of dealing with grants under section 64. GPs may not be used to giving grants to charities. I hope that the Minister will intervene to explain where GPs will get be used to giving grants to charities. I hope that the

Mr Burns: I suppose that I have had experience similar to what GPs will have, as I used to dole out section 64 grants when I was at the Department of Health in an earlier life. Some GPs will obviously be more familiar with the procedures, but I am confident that they will get to know them quickly and will soon be able to carry them out as well as PCTs do now. To totally encapsulate the point, so that the hon. Lady is fully reassured, the board will be giving guidance to consortia on how to do that.

Liz Kendall: If the board is to give guidance to consortia on the running of the section 64 grant, which is vital to many local charities—the Minister has put that on the record—I shall stop talking.

Jeremy Lefroy (Stafford) (Con): I have a question for the Minister. When I last asked whether GP consortia would be able to carry money forward—not budgets for costs, but the commissioning budget—I was told by the Secretary of State that because they were Treasury funds it could not be done. Much as I applaud it, I wonder whether the new power to make loans might sometimes be used as a method by which consortia offered loans in order to carry funding forward from one year to the next.

Mr Burns: I shall write to my hon. Friend, so that he has a categorical answer. However, off the top of my head I think that that would not apply because section 64 funding is given to voluntary organisations for the specific purposes that we have already discussed. I do not believe that it could be assimilated into a general pot for general commissioning purposes in the way that my hon. Friend suggests. If there is more to it than that, I shall write to my hon. Friend with a full explanation.

Amendment 94 agreed to.

The Chair: I invite the Government Whip to move an amendment to the programme motion.

Ordered,

That the Order of the Committee of 8 February 2011 be amended as follows: In paragraph (3) for the words from “Clauses 22 to 43,” to the end of the paragraph substitute “Clauses 22 to 38; Clauses 40 to 43; Schedule 3; Clause 44; Clauses 47 to 50; Clauses 186 to 192; Clauses 166 and 167; Schedule 13; Clauses 168 to 183; Clause 185; Clause 51; Schedule 7; Clauses 52 to 59; Clause 39; Clause 45; Schedules 4 to 6; Clause 46; Clauses 60 to 92; Schedule 8; Clauses 93 to 97 Schedule 9; Clauses 98 to 106; Schedule 10; Clauses 107 to 135; Schedule 11 Clauses 136 to 164; Schedule 12; Clause 165; Clause 184; Clauses 193 to 215 Schedule 14; Clause 216; Schedule 15; Clauses 217 to 233; Schedule 16; Clauses 234 to 236; Schedule 17; Clauses 237 to 257; Schedule 18; Clauses 258 to 260; Schedule 19; Clauses 261 to 271; Schedule 20; Clauses 272 to 274; Schedules 21 and 22; Clauses 275 to 281; new Clauses; new Schedules; remaining proceedings on the Bill.”—(Stephen Crabb.)

Mr Burns: I beg to move amendment 95, in clause 22, page 33, line 12, leave out lines 12 to 14.

The amendment is a proposal to remove subsection (3) of new section 14V of the National Health Service Act 2006, which will be inserted by clause 22. The new section concerns the commissioning guidance that is to be produced by the board and that consortia must have regard to when discharging their functions. The purpose of subsection (3) is to allow the board to obtain assistance from third parties, including NICE, in producing commissioning guidance.

Other provisions elsewhere in the Bill mean that the subsection is redundant. Clause 225 provides the necessary powers for the board to direct NICE to exercise any of its functions in relation to the preparation of commissioning guidance. The board’s general powers under section 2 of the 2006 Act, as amended by the Bill, will be sufficient to allow it to obtain assistance from others in the preparation of commissioning guidance. Subsection (3) is therefore unnecessary.

Amendment 95 agreed to.

Liz Kendall: I beg to move amendment 211, in clause 22, page 33, line 20, after ‘grant’, insert ‘or loan’.

(Stephen Crabb.)
I do not believe that that would be the case everywhere. Many GPs will want to look at other services to commission, but these two amendments would make those conflicts of interest much more clearly managed and accountable, which is why we tabled them.

Grahame M. Morris (Easington) (Lab): I rise in support of amendments 211 and 217. Amendment 211 would give an important duty to the NHS commissioning board in relation to the guidance it gives to commissioning consortia. New section 14V to the 2006 Act sets out the responsibility of the board to publish guidance for consortia on how they discharge their commissioning functions. As with much of the Bill, there seems to be little by way of teeth when it comes to regulating the functions of the new key statutory bodies it creates, such as commissioning consortia, and that is without addressing the issues of concern to the public over private providers that are looking to enter the market and that stand to gain so much from the changes.

Whatever guidance the board gives, the only obligation placed on a consortium is to “have regard” to the guidance. Time and again on earlier clauses, Ministers and Government Members have said that something is implied in the Bill, but we, on this side, want it explicitly spelt out.

When addressing the amendment, I start from the premise that far too few protections or safeguards are placed on each consortium. All hon. Members should take a moment to reflect on the fact that the legislation will transfer more than £80 billion of taxpayers’ money to GP consortia across the country. If the right safeguards are not in place before the Bill finishes its passage through Parliament, there may well be consequences and a day of reckoning for the coalition parties.

Amendment 217 would insert a specific direction to the NHS commissioning board to address the obvious and blatant conflicts of interest, to which my hon. Friend the Member for Leicester West referred, that are certain to arise out of the legislation. I draw the attention of the Committee, especially Government Members who have as yet refused to oppose any aspect of the Bill, to the written question I referred to earlier. It was a specific question about “whether a licensed private healthcare provider will be permitted to (a) provide services and (b) enter into a contract with GP consortia to carry out duties in relation to its work as a commissioning body.”

In other words, could a private health care company be a licensed provider and at the same time be contracted by a consortium as part of its commissioning arm?

4.15 pm

I was surprised by the response. I expected the reply to point me in the direction of a clear, unambiguous safeguard against what most people would agree could be a gross conflict of interest. In fact, as I said this morning, the response was:

“Consortia will be free, within the legislative framework, to make the decisions that they judge are right for patients and provide value for money.”

Mr Burns indicated assent.

Grahame M. Morris: The Minister is murmuring from a sedentary position, but I am surprised that consortia are free to do that. A reasonable person might have expected that safeguards would be in place. The answer continued:
“This includes commissioning services from the public, voluntary or private sector” and the consortia will have “the freedom to decide what commissioning activities they undertake for themselves, and for what activities they choose to buy in support from external organisations, including local authorities...voluntary sector bodies”—[Official Report, 2 March 2011; Vol. 524, c. 495W]— and private sector companies. Indeed, as the Minister indicated at Health questions earlier, it is not envisaged that GPs will spend time managing the consortium’s function. The Minister indicated that they would probably buy in that expertise, and that is increasingly the expectation.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): It is easy to read out statements completely out of context. We had the discussion earlier so I am not sure how useful this is, but we clearly said that there are clear guidelines and that each GP consortium must have in its constitution provisions for dealing with conflicts of interest. That is in the schedule, and we have already discussed it. Can the hon. Gentleman please accept that?

Grahame M. Morris: I am pleased to have the opportunity to respond. Basically, that is the nub of our argument. We want some explicit safeguards to be spelt out in the legislation, not just a vague commitment to address the issue. We want to see that in black and white in the Bill. I really think that the general public out there expect us to scrutinise the Bill properly and to ensure that that is addressed.

I will give an example in a moment, if I am allowed to continue, Mr Hood, but perhaps when the Minister has the opportunity he will respond to some of those points. It seems from the Minister’s considered written reply that he is unable to tell me where the protection exists to prevent private companies from being commissioners and providers. It is clear that the Bill permits that, and if that is not a conflict of interest, I am a monkey’s uncle. I have the attributes.

It is clear that there is more to be done to provide the public with the confidence, and to ensure, that such a gross conflict of interest does not occur, so I urge all right hon. and hon. Members to support amendment 211, which would ensure that the guidance from the board must, as the amendment says, “include procedures for the management of conflicts of interest in the commissioning arrangements of commissioning consortia, and in particular between the interests of persons engaged in commissioning services and the interests of those engaged in their provision.”

The Minister would do well to ask his colleagues to support amendment 211; it does not play well with the public to resist all our reasoned amendments. In addition, I suggest that he goes away and looks at how to put further safeguards in the Bill so that protection from such a clear conflict of interest is not only set out in guidance notes, but enshrined in legislation.

Amendment 217 aims to address another potential conflict of interest. It would place a financial duty on the commissioning consortium to prevent its members from benefiting financially from any of their commissioning arrangements.

There is plenty of evidence to suggest that that safeguard is not only required for the protection of public money and to safeguard against any conflict of interest, but desirable, to protect GPs from allegations of misuse of public money in future. Indeed, Dr Clare Gerada, the chair of the Royal College of General Practitioners, to whose evidence we have already referred, has warned that the potential conflict of interest in the current proposals could amount to a scandal on the scale of MPs’ expenses. In this case, however, it is worth remembering that we are talking about £80 billion of taxpayers’ money.

Dr Poulter: On the misspending of public money, which the hon. Gentleman is so keen to point out, would he think that when the Suffolk PCT spends £500,000 on a car park while closing front-line community hospitals, that is a good use of public money? Would he not think that GPs are much better placed to spend money on patients, rather than on bureaucracy and wasting money on car parks and infrastructure?

Grahame M. Morris: I am grateful for that intervention because it brings me to some examples that I have gleaned from the Health Service Journal. I do not condone any waste of public money, be it by the PCT, the strategic health authority or GPs. I advocate that we build into the Bill some safeguards to prevent the scope for such misspending of public money.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): My hon. Friend might want to confirm that the NHS was one of the most efficient health services in the world last year.

Grahame M. Morris: I am sorely tempted to be diverted from the amendment. My hon. Friend is right; evidence has been presented to the Committee to indicate that.

I would like to refer to some examples. I know that the Minister is not keen on that, but it might be instructive. The Health Service Journal found that where GP-led commissioning had been trialled over the last two years, funds had been diverted away from patient care to the benefit of the commissioning bodies themselves, through excessive amounts being spent on new equipment and refurbishments.

GPs have always acted as private businesses contracted to the NHS. That means that we expect them to fund their own running costs out of one budget, which will also be available for care. There will be maximum set for expenditure on management costs under the Bill, but that alone will not protect against any conflict of interests. The Health Service Journal found that by increasing spending on their own operating costs, GPs were able to increase their own practice profits.

I am sure that all Members will have also seen the Channel 4 News investigation, which revealed that under these reforms GPs could make arrangements with private sector organisations that would ensure that they can make a profit from commissioning decisions by pushing down the cost of provision. I was aware of that conflict of interest, but I was shocked by that report.

The truth is that under these reforms there is little or no protection for patient care against the conflict of interest inherent in GPs’ controlling two-thirds of the...
NHS budget. The excellent Channel 4 News investigation by Victoria Macdonald highlighted the business opportunity for private companies, which are already lining up to offer their services, and for GPs, who could work within the legislative framework to make a profit. During the course of the programme, a leaked document from Integrated Health Partners was cited as setting out a clear plan to push down the amount spent on patient care in order to push up profits and give payments to GPs.

Dr Poulter: I have to bring the hon. Gentleman back to planet Earth for a second. The fact is that the previous Government paid private companies 11% more than NHS providers to provide health care, so I do not understand where his point is coming from.

Grahame M. Morris: I am grateful again to have an opportunity—

Mr Burns: Answer the point.

Grahame M. Morris: I will answer the question, but it is important that we address the clear and present danger presented by the Bill. I will respond in a moment to the hon. Gentleman’s question about moneys spent by other organisations, but we need to address the amendment.

Mr Burns indicated dissent.

Grahame M. Morris: Well, that is what we are dealing with. I am trying to identify a problem that will arise from the Bill. The existing legislation will be amended and replaced, and I want to address certain points.

The Channel 4 News investigation stated that Integrated Health Partners “talks about plans for five per cent cost savings from patient budgets, and that the less they spend, the more there is left over to share between them”—the GP consortia which will commission it. It “even proposes that in three to five years, the overall business should become profitable enough to attract City investors. We have established that IHP is involved with a number of consortia in Surrey.”

It is not only the loopholes, which allow direct conflicts of interest to occur, that we need to consider. Commissioning consortia are not required to have some of the most basic features that we would expect in order to have transparency and openness and to carry the confidence of the British public.

As has been mentioned, there is no requirement on consortia to have a board or outside non-executive directors, to have public meetings or to publish an agenda or minutes, which primary care trusts are currently required to do. As I said, the term “GP commissioning” is an absolute red herring. There will be no requirement on GPs to play any role in management or commissioning decisions, which they can simply subcontract to a private company.

Emily Thornberry (Islington South and Finsbury) (Lab): I think that the hon. Gentleman was at Health questions before this sitting. Did he hear a Minister say that GPs did not need to cut back on the eight to nine minutes they spend per patient, because they would subcontract?

Mr Burns: No, I did not.

Emily Thornberry: It may not have been the Minister who is now jumping up and down in his seat. The point may have been made by the Secretary of State.

Grahame M. Morris: I recall that very clearly. It was said in reply to a question from my hon. Friend the Member for Stockton North (Alex Cunningham), and I may have referred to that in my opening remarks, because the suggestion from the Minister—we can check Hansard—was that GPs would not have to reduce the time spent, which is eight or nine minutes on average.

Mr Burns: Will the hon. Gentleman give way?

The Chair: Order. Before the hon. Gentleman answers the question whether he will give way, I say to Ministers that I can hear you whispering away, when you should be listening to the Member who is addressing the Committee. As I have previously asked, I hope that right hon. and hon. Members will pay attention.

Grahame M. Morris: Thank you, Mr Hood. I just want to answer the question, and then I will give way to the Minister.

The Minister’s response was that there was no need for GPs to set aside time for training in commissioning, because—[Interruption.] That is the answer that he gave, and we can check Hansard. He is grimacing.

Mr Burns: It was me.

Grahame M. Morris: I know who it was, but I am not going to identify him. The suggestion was that the expertise would be bought in. Clearly, the Bill allows for that, and however the Minister wriggles on it, the written record is absolutely clear: in response to parliamentary questions, he gave assurances that are implicit, not explicit.

Mr Burns rose—

4.30 pm

Grahame M. Morris: No, I am going to make some progress, because I am almost finished, and the Minister will have ample opportunity to respond.

With the limits on management and administration spending set out in the Bill, the pressure will obviously be to delegate commissioning decisions elsewhere. The most likely scenario seems to be that the entire commissioning function will be contracted out over time to private companies and there will be no proper scrutiny or accountability—remember, they do not have to respond to freedom of information requests, for example. Will the Minister act before it is too late, not just by accepting the amendments but by putting the tightest regulations possible in the Bill to safeguard against the misuse of public money?
shown in up and down like a yo-yo. What I actually said will be what was going on; he was concentrating on jumping the hon. Member for Easington was not listening to think that in his keenness to be called by Mr Speaker, who answered the oral question from the hon. Member the same Health questions as I was, because the Minister for Stockton North—I shall be quite frank—was me. I think that in his keenness to be called by Mr Speaker, the hon. Member for Easington was not listening to what was going on; he was concentrating on jumping up and down like a yo-yo. What I actually said will be shown in Hansard tomorrow. The question from the hon. Member for Stockton North said that patients got only eight or nine minutes with their GP I said that I did not accept that figure because I believed, from my experience of going round the country, that GPs made as much time available as they thought was appropriate to see their patient. That is completely different from the fantasy land revealed by the comments made by the hon. Member for Easington.

Grahame M. Morris: That was not the question at all. I know that we are deviating from the amendment, Mr Hood. The question is: what estimate has the Minister made of the average amount of time per week—

The Chair: Order. Much as it may be tempting to have another go at Question Time today, it is not in order for this Committee to do so. I invite the Minister not to encourage other hon. Members to follow the wrong route.

Mr Burns: I certainly will not, Mr Hood. Would it be in order, though, for me just to explain to the hon. Member for Easington that he is confused because—

The Chair: No.

Mr Burns: It is not, so I shall stop there.

What is more in order, and which I will mention in passing, is that it was significant that the hon. Member for Easington failed to answer, although he promised to, the extremely pertinent point made by my hon. Friend the Member for Central Suffolk and North Ipswich, because that goes to the nub of what has been going on with independent sector treatment centres. ISTCs were private providers, set up by the last Government—

Liz Kendall rose—

Mr Burns: One minute—let me finished. The hon. Lady cannot have been enraged so much so soon, when I have not actually finished what I am saying. When I have finished, I will give way to her. The point that my hon. Friend made was that we had a system, set up by Tony Blair, which was to cherry-pick certain services at the expense of the local NHS provider and to encourage them—/[Interruption.]
in favour of such things—not in favour, I hasten to repeat, before anyone misunderstands or mishears—and I will demonstrate that we have put necessary safeguards in place to ensure that the potential for such conflicts is transparently and properly managed.

Respondents to the “Equity and Excellence” White Paper consultation supported our proposals to put systems in place to ensure fairness and transparency in decision making, particularly in relation to any decisions to commission services from GP practices. We have therefore laid down in the Bill measures that ensure, in an environment of flexibility and freedom, that the actions and decisions of consortia and their member practices are transparent and appropriate.

Clause 63 is important in that regard. It allows for regulations to impose requirements on both the board and consortia so that when commissioning services they adhere to good practice in procurement. Regulations may impose requirements relating to “the management of conflicts between the interests involved in the commissioning of services and the interests involved in providing them.”

Amendment 211 would require the board to include in its commissioning guidance for consortia guidance on arrangements to manage conflicts of interest. The regulation power in clause 63 to impose requirements about conflict is stronger than that. In addition, paragraph 4 of new schedule 1A to the National Health Service Act 2006, inserted by schedule 2 to the Bill, requires each consortium to set out its arrangements for managing potential conflicts of interest. Consortia will have the flexibility to specify their own arrangements, but it will be the role of the board to review and approve those arrangements as appropriate.

As part of the establishment process for consortia, the NHS commissioning board must be satisfied that the applicants have made appropriate arrangements to ensure that the consortium will be able to discharge its functions. The board will review consortia constitutions for evidence that clear arrangements are in place to discharge their functions, including promoting choice and managing potential conflicts of interest. If the board is not satisfied that the proposed arrangements are adequate, it will simply not establish the consortium.

Doctors are also bound by a duty under General Medical Council guidance that any commercial interest GPs might have in a company must not affect how they refer a patient. If they do decide that it is most clinically appropriate to refer a patient to a company in which they have an interest, they must inform the patient of that interest. Such commercial interests might take the form of shareholding in or ownership of companies providing community-based services, such as dermatology or podiatry.

Liz Kendall: Is the Minister saying that patients must be informed every time a GP refers them to a dermatology or any other service provided by an organisation in which the GP has some kind of interest?

Mr Burns: Yes, I am.

Liz Kendall: Is the Minister guaranteeing that?

Mr Burns: The hon. Lady asked a question, and my answer is yes, the GP must inform the patient every time. She went further, to ask whether I am guaranteeing that—an interesting point but clearly, it would not be realistic of me to stand here and guarantee that every time a GP sees a patient in certain circumstances he will do what he ought to do.

To strengthen my argument—I alluded to this just now—GPs currently have a duty under GMC guidance, and that will not change under the modernisation proposals. It is probably fair to say that Members of all parties feel that the duty under the current GMC guidance is satisfactory. In that case, logically, they should also expect and accept that that will remain so under the modernisation of the NHS. It would be slightly contradictory to take another view.

Owen Smith: Does the Minister not agree that nothing in what he has just said outlaws a situation arising under the Bill whereby a private provider might be contracted both to commission and then to provide a service? All he is saying is that the consortium needs to have in place appropriate mechanisms to deal with such conflicts, but they are not outlawed from occurring. Am I right or am I wrong?

Mr Burns: I will not say what I was about to say in reply to that last question. I will say that I fully understand that the purpose of the Committee is to hold the Government to account and to question our purposes and what a piece of proposed legislation will achieve or not, depending on one’s point of view. However, let me say this: hold the Government to account by all means, and ask questions by all means, but let us not be too pedantic. The system works at the moment, and I imagine that the hon. Gentleman had never questioned it as a system that did not work until this afternoon when we reached the clause. At the moment, GPs have a duty in similar circumstances, under GMC guidance. What is more, it is a matter of—

Owen Smith: The Minister has not answered the question.

Mr Burns: I have answered the question.

Owen Smith: No you have not.

The Chair: Order. It is for the Minister to respond to an intervention in the manner he feels fit.

4.45 pm

Mr Burns: I want to be helpful to the Committee, and I hope that hon. Members agree that I have been over the past few weeks. On this narrow issue, however, I am satisfied that I have outlined, with great clarity and
detail, that the system that works at the moment will be just as effective and relevant with GP consortia. I do not accept that there is a problem. The hon. Member for Pontypridd is making a meal out of this, particularly as the regulations made under clause 63 will set requirements in relation to conflicts of interests. We are not using only one mechanism to minimise the potential for such conflicts; we are using a number of them, including those that we have been discussing—the General Medical Council guidance and professional standards.

Owen Smith: May I help the Minister understand? With respect, the simple point we are trying to make is that there is a radical difference between an individual GP who may have an interest in a company to which he refers a patient, and BUPA running both the commissioning for a slew of GPs across a given area and then the service provision at the other end. That is the difference. Is that latter scenario possible and will it be dealt with? Our contention is that it looks feasible under the legislation.

Mr Burns: Before I answer the hon. Member for Pontypridd, I will give way to my hon. Friend, because he has a medical background, and far more experience than the hon. Gentleman, I suspect, who does not have a medical background. I think it will be useful and of interest to the Committee to hear from him before we proceed.

Dr Poulter: It is worth drawing out briefly the fact that the very issue that the hon. Gentleman has just raised, arises in hospitals at this moment, because of the policies put in place by the previous Government. In fact hospital services are already contracted out on a large scale by the NHS, often paying private providers a lot more than NHS service providers, as I outlined earlier. The same consultants will be doing the same operations at different ends of the hospital, one for a private provider, and one for the NHS.

The Chair: Order. It is a bit strange for Back Benchers to be answering interventions for Ministers. I would much prefer the Minister not to take such long interventions from his hon. Friends.

Mr Burns: Notwithstanding its length, I think the content of my hon. Friend's intervention was rather useful for Opposition Members. Although I am grateful for the information, I will also provide an answer myself, which was the intention. I thought that the hon. Member in particular could benefit from the medical and health background of my hon. Friend before we progress. The fact is that, yes, a company could assist with commissioning and be involved in provision, but—there is a but—only if all regulations and requirements are being fulfilled; furthermore, as I said, there are protections, including those of the GMC, by which it has to abide in order to minimise a conflict of interest. The hon. Lady looks staggered.

**Mr Simon Burns**

Mr Burns: I honestly think that I should move on, because we have exhausted the subject, although I accept that the hon. Gentleman does not agree.

The arguments about measures to safeguard against conflicts of interests apply equally to amendment 217. It is simply not the case that member practices will be able to pocket savings from their commissioning budgets. With the exception of the funding for administrative costs, which is to cover the costs of commissioning, the consortium's commissioning budget must be used exclusively for the commissioning of patient care. Commissioning budgets will also be distinct from the income that GP practices earn under their primary medical care contract, from which GPs meet their practices expenses and derive their personal income.

There seems to be an element of confusion, so it might help the Committee if I give a little background detail to the quality premium. The premium is a financial incentive to reward effective commissioning in the same way that quality and outcomes framework payments provide incentive for effective health care provision. The quality premium is intended to encourage GP-led commissioning consortia to achieve high-quality health outcomes from within NHS resources. It will be funded from existing resources, and the Department will continue to discuss with the profession the nuts and bolts of its design.

I think I have dealt with the query raised by the hon. Member for Easington about whether a private contractor could be contracted by its commissioning arm to be part of commissioning functions. He cited my answer to his recent written parliamentary question, in which I said that there would be flexibility for consortia within the rules set out in the legal framework. Those rules include regulations and requirements on procurement practice and the safeguards that I have already set out in my response.

Grahame M. Morris: Will the Minister just give a straight yes or no answer to this question: can a private sector company that is engaged by the GP-led commissioning consortia be both commissioner and provider?

The Chair: Order. The hon. Gentleman must be standing when he makes contributions to the Committee.

Mr Burns: I am a bit perplexed by the hon. Gentleman's question, because there will be certain circumstances, as there are now, where a GP may be also attached to a provider of a service in some shape or form. Provided that the safeguards and protections that I have outlined are in place and operate, I do not have a problem with that. I am not sure why he has a problem. It may come as a surprise to him, but that has been going on for years. It is not as though some completely new procedure has suddenly been revealed to him; it has been happening for a long time. GPs will refer people to treatments or care in certain circumstances, with protections against conflict of interest, and I do not understand why he has a problem.

Owen Smith: May I help the Minister understand? With respect, the simple point we are trying to make is that there is a radical difference between an individual GP who may have an interest in a company to which he refers a patient, and BUPA running both the commissioning for a slew of GPs across a given area and then the service provision at the other end. That is the difference. Is that latter scenario possible and will it be dealt with? Our contention is that it looks feasible under the legislation.
Emily Thornberry: I am staggered. The reason I am so staggered is that the hon. Gentleman says, “There will be regulations. Everything will be fine.” We have not seen the regulations. This is a very serious matter. The Minister cannot simply say, “Oh well, we are sure the General Medical Council will sort it out,” or, “We will have some regulations,” That is not good enough.

Mr Burns: I have waited 13 sittings for a Labour Member to make that point. I should like to point out to the hon. Lady that we have reversed a trend to which we became accustomed between 1997 and 2010. Some hon. Members have criticised the length of the Bill, but the reason for its length is that we have sought to reverse recent precedent and insert as much relevance as possible into the Bill and primary legislation—unlike the health Bills of 1998-99, 2002-03, 2006 and 2009, in which the previous Government adopted the deliberate tactic of providing Committees and the House of Commons with a skeleton, while all the powers and detail flowed from regulations, statutory instruments and other secondary legislation, but when the Bills were progressing through Committee, no guidance and no draft statutory instruments had been published.

I represented the then Opposition on the Health and Social Care (Community Health and Standards) Bill Committee in 2002-03 and, to be frank, I made the same plaintive plea on far more occasions than the hon. Lady has; the difference was that there was virtually nothing on the face of the primary legislation. We have decided that it is only right and proper that to insert in the Bill as much information as we can for the Committee’s consideration. It is inevitable, however, that there will be a number of provisions from which statutory instrument regulations will flow. We cannot put everything on the face of the Bill.

It says in my speaking notes, “I hope that I have satisfied the concerns of hon. Members on this point,” but I can tell my hon. Friends that I will not have done so. I have reached the point of believing that nothing will satisfy or convince Opposition Members.

Emily Thornberry: Give up.

Mr Burns: Never give up. I ask the Opposition to reflect upon the debate and to consider withdrawing the amendment.

The Chair: Order. Before I ask the hon. Member for Leicester West to reply, I once again remind Members that it is not good enough for them to heckle others in Committee. There has been to-ing and fro-ing—no one side has been doing it more than the other—and I will jump to my feet in future to bring it the Committee’s attention. It is not satisfactory for people who watch and read our proceedings to hear that sort of heckling. I deprecate it and invite Members to listen to those who are on their feet, to intervene briefly, and to address the amendments under consideration.

Liz Kendall: Let me explain why the Opposition are not satisfied with the Minister’s explanation. He frequently asked why we are complaining now, when this has always been the case and nothing much is changing. The General Medical Council already requires GPs to disclose whether they have an interest in a particular company to which they refer a pensioner, and the hon. Member for Central Suffolk and North Ipswich has said that GPs are already able to refer someone to a private provider where they or one of the colleagues work. The difference, though, is that GPs do not currently have responsibility for commissioning £80 billion-worth of the NHS budget. For all their faults, as well as some of their benefits, primary care trusts have a board, a chair, and executive and non-executive directors. The new body being established has no requirement to involve a GP, let alone any other provider, on its commissioning board. That is why we are so concerned.

I hope that the Minister will allow me to make some progress here. He has made his point about why he thinks the amendments are not sufficient. I am setting out the case for why they are. We are concerned because, although some of the issues may be the same, the point is that the Bill changes the structures that deal with them and the accountability in those structures, and for the first time it gives GPs a role as commissioners of services, not just providers. There is no GMC requirement, as I understand it, for a GP to disclose anything involving a conflict of interest in terms of commissioning. It is about the provision of services, which is why we have tabled the amendments.

5 pm

I thought that the hon. Member for Central Suffolk and North Ipswich was uncharacteristically ungentlemanly in his suggestion that my hon. Friend the Member for Easington was somehow living in a fantasy world when he talked about the potential for a conflict of interest if a private provider could both commission and provide a service.

I do not want to stray beyond the scope of the amendment, Mr Hood, so I shall not comment on whether the policy is good or bad. I am talking about the reality—what could happen. It is not fantasy. According to Pulse magazine today, the spokesman for the consultancy McKinsey—a private provider—has said it is “supporting ‘more than two dozen’ consortia on commissioning”.

Other organisations are helping GPs in both the commissioning and provision of services. That is not a fantasy; it is happening. As I said, I am not commenting on whether that is good or bad. I am saying that there must be proper accountability to avoid conflicts of interest. The Bill does not provide that. There are indeed issues to do with a clear process in procurement, but the question is the lack of accountability of the proposed new consortia, which we have discussed previously.

The Minister said that it was not possible for GPs to benefit personally from the commissioning decisions that they take, such as if a surplus is made. He talked about the premium and the quality and outcomes framework. We will, with the next group of amendments, reach a direct contradiction, in the Bill, of what he asserted. I shall not discuss it now as it is an issue that requires full discussion under clause 23.

The Bill changes the current situation as to the roles and responsibilities of GPs, giving them a strong role in commissioning as well as in providing services. That is why we propose a change. I do not believe that the Minister has responded to those questions.
Amendment 143 would delete subsection (4) of new section 14V and instead require the board to consult “bodies and persons with professional expertise relating to patient and public involvement and review and scrutiny” before publishing commissioning guidance.

New section 14V requires the NHS commissioning board to publish guidance for commissioning consortia on the discharge of their commissioning functions. Each commissioning consortium must have regard to that guidance. Subsection 14V(4) requires the board to consult the HealthWatch England committee of the Care Quality Commission before publishing commissioning guidance and before publishing revised guidance containing changes that the board considers significant.

The amendments propose extending those consultation requirements beyond HealthWatch England. However, I would expect HealthWatch England to include persons with professional expertise in patient and public involvement and scrutiny, and I am not convinced of the need to go any further. In addition, the board may enter into arrangements with other persons to assist the board in the preparation of guidance. That will ensure appropriate expertise in producing the guidance. For those reasons, I urge the hon. Lady to withdraw the amendment.

Emily Thornberry: I beg to move amendment 96, in clause 22, page 34, line 5, leave out ‘each financial year, each’ and insert ‘each relevant period, a’.

The Chair: With this it will be convenient to discuss Government amendments 97, 98, 101 to 103 and 105.

Mr Burns: This is a series of seven amendments to new sections 14Y, 14Z, 14Z1 and 14Z2. The Committee might find it helpful if I addressed them in three groups.

Amendments 96, 97 and 98 would together ensure that new consortia were obliged to produce a commissioning plan in respect of the remainder of the financial year in which they were established. Subsection (1) of new section 14Y requires every consortium to prepare a commissioning plan before the start of each financial year. Such plans set out how the consortium proposes to exercise its functions in that year. However, that requirement cannot logically be met for the year in which a new consortium is established. If the consortium did not exist before the start of the financial year, the obligation to produce a commissioning plan could not properly apply under the current wording.

I am sure that hon. Members will agree that such a situation is not desirable. It is for that reason that I propose amendments 96, 97 and 98. These amendments modify the link between plans and financial years by introducing the concept of a “relevant period” for which the consortium must prepare a commissioning plan. That would allow the board to direct new consortia to prepare a plan covering the period between establishment and the end of the financial year.

For consortia that are already in existence at the start of a financial year, these amendments make it clear that the “relevant period” relates to the forthcoming financial...
year. In so doing, the amendments ensure that every consortium, regardless of when it is established, is obliged to produce a commissioning plan for each financial year.

The second issue is addressed by amendments 101, 103 and 105. It is not the most controversial issue that the Committee will be asked to consider. These amendments simply tidy up separate definitions of what constitutes a “financial year” with a single definition that applies to all the new sections of the National Health Service Act 2006 that the clause will insert. The definitions of a “financial year” contained in new section 14Y and new section 14Z1 are identical. For that reason, it is preferable that these definitions should be removed in favour of inserting a single definition in new section 14Z9. Hon. Members will note that that new section is on “Interpretation”, which will contain the provisions set out in clauses 21 and 22.

Finally, amendment 102 amends new section 14Z1, which would require a consortium to produce an annual report setting out “how it has discharged its functions in the previous financial year.”

As it is currently drafted, new section 14Z1 requires a newly established consortium to provide a report for the previous year, in which of course it did not exist. Amendment 102 rectifies that. The intention is to make clear what common sense would conclude.

Taken together, the amendments are proposed in the interests of common sense and good housekeeping, and I trust that they will be acceptable to the Committee.

Amendment 96 agreed to.

Amendments made: 97, in clause 22, page 34, line 7, leave out ‘year’ and insert ‘period’.

Amendment 98, in clause 22, page 34, line 7, at end insert—

'(a) in subsection (1), “relevant period”, in relation to a commissioning consortium, means—

(a) the period which—

(i) begins on such day during the first financial year of the consortium as the Board may direct, and

(ii) ends at the end of that financial year, and

(b) each subsequent financial year.'.—[Mr Simon Burns.]
We are concerned that it would be left to the consortia to decide what is significant, although we have no argument with the fact that a consortium might want to revise a plan at some point. The Opposition would be more comfortable if there were some recourse to the health and well-being board or the local authority. They could be consulted on what could be termed “significant” and could negotiate on that. I would be very concerned if the amendment were left in this state. I hope that the Minister will take it away and look at how it could be strengthened.

Mr Burns: The short answer is no, simply because I do not share the hon. Gentleman’s concerns. I happen to think that it is relevant and appropriate for the consortia to do that. They have to consult the relevant health and well-being boards on whether the plans properly take into account the most recent joint health and well-being strategy published by that health and well-being board, which I think is logical and a sufficient safeguard to prevent the sort of problems that the hon. Gentleman says might happen. I think that the consortia are the right people to deal with this. I hope that that allays the shadow Minister’s fears.

Derek Twigg: I am sorry to disappoint the Minister, but my fears are less than allayed. There is a clear requirement on the plan to have this consultation with the health and well-being board, but the revision could be significant and could alter the commissioning plan. We do not argue that they have to consult unless the consortium deems that to be the case. The amendment is woolly in that there may be some guidance published by the board, but that is not necessarily required. I am very concerned. The Minister has not answered my question about why we need two separate paragraphs about significant changes around preparation and significant changes to the plan.

Mr Burns: I am sorry, but I have to say that the amendment ensures that when consortia intend to revise their plans, they are obliged to consult the relevant health and well-being boards when making significant revisions. I am not a lawyer, but I think that “significant” is a catch-all word so that we do not have this procedure for really minor, irrelevant changes. I think the hon. Gentleman will accept that point as viable.

Can I say before he comes back that the requirement for the consortia to consult the relevant health and well-being boards when they intend to revise their plans is consistent with the requirement of the health and well-being boards to be consulted when producing a plan in the first instance? There is consistency, and I think that is a safeguard with regard to revisions. I accept that, where a health and well-being board has been consulted, consortia must include a statement of the board’s opinion in the revised plan, which I also believe is a protection because it will be in the public domain.

Derek Twigg: We are not dancing on the head of a pin here—“significant” has not been defined. While a very well run consortium may decide to consult on a variety of changes, there is no requirement as to what they must consult on. Nor is there any requirement on the board to produce guidance—the provision says that it “may” do so. Quite frankly, I think this is a poorly written amendment.

I completely accept that the board should be able to revise its plans, but the Minister seems unwilling to take this back and look at it. He has also not answered my other question; perhaps I can get the answer now. Why are there two specific applications, in terms of significant changes to the preparation of the plan and significant changes to the plan itself, which come in (8B) and (8C) of the amendment? The Minister may want to write to me about that, but my main point is that I am not satisfied with the assurances that he has given. I urge him again to take the amendment away and have a look at it. Otherwise, we will be forced to vote against it.

Mr Burns: I am not convinced that this will satisfy the hon. Gentleman, but on the question of why there are separate paragraphs on the plan and the preparation, the answer is simply for drafting clarity. We are not trying to hide anything. If the hon. Gentleman would prefer me to write to him in greater detail to expand on that explanation, I will be more than happy to, but if he is satisfied, I will not, so long as he nods his head.

Derek Twigg indicated assent.

Mr Burns: Thank you.

Question put. That the amendment be made.

The Committee divided: Ayes 12, Noes 11.

Division No. 29]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

NOES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Shannon, Jim

Question accordingly agreed to.

Amendment 99 agreed to.

Mr Burns: I beg to move amendment 100, in clause 22, page 34, line 33, leave out ‘established for an area which’ and insert ‘established by a local authority whose area’. I hope that we can deal with this swiftly because the amendment corrects a minor and technical inaccuracy. As drafted, subsection (9) describes health and well-being boards as being “established for an area” In fact, the reference should be to the local authority area. As clause 178 will make clear, health and well-being boards are to be statutory committees of local authorities. They will not have an area in their own right distinct from that of the local authority that establishes them.
It is more accurate to refer to “a local authority area” for the purpose of identifying a relevant health and well-being board, and that is what the amendment makes clear. The intention is to define which health and well-being board or boards must be consulted by a consortium when it prepares its commissioning plan under the duty in new section 14Y. A relevant board will be one established by a local authority whose area coincides with, or includes, the whole or any part of the area of the consortium.

Amendment 100 agreed to.

Amendments made: 101, in clause 22, page 34, leave out lines 35 to 37.

Amendment 102, in clause 22, page 34, line 39, after “financial year”, insert “other than its first financial year.”—[Mr. Simon Burns.]

Liz Kendall: I beg to move amendment 213, in clause 22, page 35, line 18, at end insert—

‘(3A) The Board must, after consultation, define and publish the criteria by which performance will be measured.’

The amendment relates to the important issue of the responsibility of the NHS commissioning board to conduct an annual performance assessment of every consortium. If the Government proposals go through—we hope they will not—the consortia will have £80 billion of taxpayers’ money to spend, and it is vital that proper processes should be in place to ensure that the performance of those consortia are properly assessed.

However, many GPs are concerned that there is no requirement within the legislation for the board to publish or define the criteria by which it will assess whether a consortium has performed well, or to consult on that or publish it. The amendment would ensure that the board defines, consults on and publishes the criteria by which performance will be measured. That is important not only for the effective functioning of the consortia but, as we shall see under clause 23, for other related issues, which are extremely important but which I shall save for the delight of hon. Members. Members in a few moments.

5.30 pm

Mr Burns: The amendment concerns the performance assessment of consortia by the commissioning board, as the hon. Lady said. It would require the commissioning board after consultation to define and publish the criteria by which performance will be measured. New section 14Z1 of the 2006 Act specifies that the board must conduct an assessment of how well each consortium has discharged its functions during each financial year. The amendment is unnecessary. New section 14Z1 also specifies that the performance assessment of a consortium should consider, in particular, how well the consortium has discharged its financial duties and its duties to make continuous improvement to the quality of services.

Subsection (4) allows the Secretary of State to publish a document about consortia performance assessment, which the board must take into account when drawing up such arrangements. Drawing on the NHS outcomes frameworks, the NHS commissioning board will develop a new commissioning outcomes framework to help consortia account for effective commissioning. The framework will allow the board to identify the contribution of consortia to achieving the priorities for health improvement. It will be for the shadow board to take forward work on developing the framework during 2011-12. To help maintain momentum, the Department will publish a discussion document seeking the views of stakeholders on possible features of the framework. Consultation will, therefore, be forthcoming.

On financial performance, quite simply consortia will be under a clear duty to ensure that their expenditure does not exceed the commissioning budgets allocated to them.

Liz Kendall: What will happen if they do not stick within their budgets?

Mr Burns: I do not think the problem will arise because they will not be allowed to go beyond their budgets. That is the whole point. They will have to remain within their budgets.

Liz Kendall: That is the situation at the moment, but PCTs go over budget. What will be different this time?

Mr Burns: The fact that consortia will not be able to exceed their budgets. Of course, they will have help and assistance with that through the guidance—

Liz Kendall: Will the Minister give way?

Mr Burns: How can the hon. Lady intervene when she has not listened to the conclusion of my sentence? They will have guidance, help and assistance through the national commissioning board, because one of its responsibilities will be to ensure that consortia keep within their budgets.

Liz Kendall: PCTs have guidance, help and assistance at the moment from SHAs and often, I would say, from the Department of Health, but some of them go over budget. Why will it not happen this time? What is different?

Mr Burns: As the hon. Lady knows, the situation with regard to PCTs is that for some years there has been a mechanism within the system for them sometimes to go over budget in a year. As long as over a three-year period they break-even and redress the problems of the deficits in each year, they fulfil their obligations.

Liz Kendall: Under the Bill, the NHS commissioning board will also top-slice GP consortia to create a contingency fund. It is exactly the same as it is at present, but the Minister has contradicted that by saying that GP consortia will not be able to go over their budgets; which is the real answer?

Mr Burns: I thought I was explaining the situation with PCTs. Consortia will have a clear duty to ensure that their expenditure does not exceed the commissioning budgets allocated to them. I do not think that the next thing I am going to say will satisfy the hon. Lady: it is that I hope my remarks reassure hon. Members that the measures against which consortia will be held to account will be developed in an open and transparent way. As I said before this broad, sweeping statement about the
financial position, the framework will allow the board to identify the contribution of consortia in achieving priorities, health improvement and developing the framework, but that will be done during 2011-12, under the auspices of the shadow board—

Emily Thornberry: I want to be sure I understand. Does it mean that, if four elderly gentlemen came to a commissioning consortium at the end of the financial year, all needing heart bypasses, none of them would be allowed one until the new financial year?

Mr Burns: No, it does not. Before such a suggestion sets any hares running, I repeat, once and for all, that that is not what will happen.

The shadow commissioning board will be working on the framework during 2011-12. Consortia are expected to stick within their budgets. If they go over, a centrally held contingency fund will help them in the short term, but the guiding principle will be that they are not expected to go over their budgets.

With that in mind, I beg to move the amendment—
[Interruption.] I apologise—I oppose the amendment.

Liz Kendall: I shall be generous: we accept that the Minister does not agree with the amendment.

I want to deal with the money first: we accept that the Minister does not agree with the amendment.

Mr Burns: Yes, go on.

Liz Kendall: Thank you.

In reality, at present PCTs are “not allowed” to go over their budgets, but they do. A top-sliced fund at the strategic health authority level manages such situations. All SHA—as anyone who has worked in a PCT knows—are extremely rigorous in pressing PCTs to keep within their budgets, but sometimes that does not happen. The reason is that in some parts of the country there are huge structural deficits that have been there for a long time and that are difficult to assess without undermining the financial position of hospitals. If we were to get rid of those structural deficits, some hospitals would have to close. That is the reality.

Under the system proposed by the Government, consortia may be required not to go over their budgets, but simply asserting something in the NHS does not make it happen. Even if the structural debt problems relating to hospital services and some areas’ long-term difficulties are addressed, some GP commissioning consortia will still have deficits, which is why the Government are proposing that the NHS board will top-slice consortia and hold a contingency fund. So we will be going through a huge reorganisation to end up in the same position. In fact, as we heard in evidence to the Committee, some consortia might find it harder to stay in budget if they cover a small population—a point made by my hon. Friend the Member for Islington South and Finsbury—because only four or five expensive patients could put such a consortium into debt.

The Minister’s claim, simply that consortia have a duty to stick within their budgets, will not achieve his desired goal, which is keeping the NHS in balance. He is replacing one system with a similar system, but with organisations that are smaller and that might find it more difficult to handle financially. That was not the point of the amendment, but the issue was raised. It is important for the Committee to realise that things will be no different in trying to address the structural debt in particular parts of the country.

I am reassured by the Minister’s comment that there will be a consultation on how the performance of consortia will be assessed in relation to the outcomes framework, which is a welcome development. I wanted to place on the record my comments about the financial problems that consortia will face, because those problems will remain and might become worse, but I will not press the amendment to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment made: 103, in clause 22, page 35, leave out lines 26 to 28.—[Mr Simon Burns]

Mr Burns: I beg to move amendment 104, in clause 22, page 38, line 24, leave out from ‘if’ to end of line 25 and insert—

‘its area coincides with, or includes the whole or any part of, the area of the consortium’.

I hope I can reassure the Committee that the amendment is minor and technical. The intention is to define which local authority or authorities will be considered relevant, and accordingly must be consulted, before the NHS commissioning board dissolves a consortium, exercising its power of intervention under new section 14Z6(7) of the 2006 Act. The proposed new definition of a relevant local authority depends on whether its area coincides with or includes the whole or any part of the area of the consortium. The change of wording introduced by the amendment is not substantive. It will mirror the provision in new section 14Y(9), in which the definition of local authority areas determines which health and well-being boards must be consulted when consortia prepare commissioning plans.

Amendment 104 agreed to.

Amendment made: 105, in clause 22, page 39, line 11, after ‘Chapter,’ insert ‘—

“financial year”, in relation to a commissioning consortium, includes the period which begins on the day the consortium is established and ends on the following 31 March;’—[Mr Simon Burns.]

Clause 22, as amended, ordered to stand part of the Bill.

Clause 23

FINANCIAL ARRANGEMENTS FOR CONSORTIA

Liz Kendall: I beg to move amendment 216, in clause 23, page 39, line 29, at end insert—

“(2A) In determining the amount to be allotted to a consortium, the Board must have particular regard to—

(a) its duties under 13F(1)(a) and 13F(1)(b) of the National Health Service Act 2006, and

(b) the health needs of the consortium population.”.

The clause, as hon. Members know, deals with the financial arrangements for consortia. The amendment makes the important point that, in determining how
much money the NHS commissioning board allocates to consortia, it should take into account not only the previous year’s expenditure and the amount set aside for the contingency fund, as the Bill currently states, but crucially the board’s duties in relation to the NHS and the health needs of the local population.

How much money consortia received in a previous year and how much the board has decided to top-slice to deal with consortia getting into debt—an issue we have just raised—cannot be the only measures by which the board determines how much money should be allocated to consortia. That is why the amendment would insert these two other criteria: the duties that consortia are supposed to achieve and, crucially, the health needs of the local population.

Mr Burns: The amendment would place a duty on the board to have particular regard to local health needs, and to its existing duties under new section 13F of the 2006 Act, which requires it to have regard to the need to reduce inequalities when determining allocations to consortia.

My hon. Friend the Member for Stafford moved an interesting amendment on Thursday on a relatively similar issue. I am sorry that I had to leave that discussion early to respond to an Adjournment debate downstairs. In responding to that amendment, I stated a number of the factors that are currently taken into account in the way in which allocations to primary care trusts are formulated, and which we expect the commissioning board to continue to consider when allocating funds to GP consortia.

It is not necessary for me to go into too much detail, having explained what is in the Bill and the Government policy behind it; nor was it necessary to table this amendment. However, it is important to remember that we are establishing an independent commissioning board that will be responsible for the allocation of NHS resources to consortia free of political interference. The process for developing the allocations formula is complex, taking into account the age of the local population, levels of deprivation and local, unavoidable cost differences reflected in the market forces factor, such as staffing, land and buildings costs.

5.45 pm

The White Paper, “Equity and excellence: Liberating the NHS”, stated that allocations should be made “on the basis of seeking to secure equivalent access to NHS services” relative to the prospective burden of disease and disability. As I said on Thursday, the board will need to consider its duty under new section 13F of the 2006 Act to “have regard to the need to…reduce inequalities between patients with respect to their ability to access health services” when exercising its functions, including allocating funds to consortia. Furthermore, under new section 223H of the 2006 Act, the board must allocate funds to the consortia for the performance of their functions to deliver the services needed for their local area. In doing so, it will of course have to take account of the particular needs in that area.

On Thursday, many of the points made by hon. Members were on issues relating to wider determinants of health and their impact on health inequalities and demand for NHS services. Tackling health inequalities is at the centre of our approach to public health. The Government have made it clear that tackling health inequalities is a priority as part of the commitment to fairness and social justice. We have said that on several occasions in debates on earlier parts of the Bill. We are currently consulting on the detail of both the public health outcomes framework and funding and commissioning routes for public health.

For the first time in a generation, local government will be given the responsibility for making a major impact on improving people’s health and tackling health inequalities in every community. There will be ring-fenced budgets for upper-tier and unitary local authorities and a new health premium to incentivise action to reduce health inequalities. That will apply to the part of the local public health budget that is for health improvement. Building on a baseline allocation weighted towards areas with the worst health outcomes and most need, the health premium will depend on the progress made in improving the health of the local population, based on elements of the proposed outcomes framework.

The Government’s reform and the proposals in the Bill will enhance opportunities to address health inequalities and support integrated action to tackle the wider determinants of health. Therefore, although I agree with the purpose of the amendment, it is not necessary and would not add anything to the value of the Bill. For that reason, I urge the hon. Member for Leicester West to consider withdrawing it.

Liz Kendall: The Minister has addressed my concerns that the funding allocation for consortia should be based on the health needs of the population and the functions and duties of the consortia in relation to continuously improving health care and addressing those health needs. I just want to put it on record that we thought that the duties themselves should be amended, but as long as they are not only on the basis of what is in the clause as currently written, I am happy to withdraw the amendment.

I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.
The board can make one, two, three or however many bonus payments it wishes. It will then be up to the commissioning consortium to do whatever it wants with those bonus payments. The board can also determine their size. In other words, the Bill allows for performance-related bonus payments to be made by the national board to GPs, and the money could go into the GPs’ private pockets and not be re-invested in patient care. That is what the Bill says; that is what it allows.

The matter has been raised by Dr Peter Carter, the chief executive of the Royal College of Nursing. In evidence to the Health Committee, he said that “there should be no question of it”—the money—“being put back into people’s pay packets or giving people bonuses. This is taxpayers’ money. Any surplus should be ploughed back into patient care, not extra pay and bonuses for those who are already reasonably well paid.”

Dr Clare Gerada, the chair of the Royal College of General Practitioners, has also raised concerns about the ability under the Bill for bonus payments to be made. She said that they would be “unethical”.

On 15 February, the Under-Secretary of State for Health, the hon. Member for Guildford (Anne Milton), wrote to The Guardian. She said,

“I want to reassure Dr Peter Carter, Dr Clare Gerada and any concerned MP”—I assume that she meant Opposition Members—“that there is no way GPs will be able to pocket any money not used from their allocated budget as a bonus. The budgets of GP consortiums will be used exclusively to fund patient care. High-performing consortiums may be awarded a quality premium by the NHS Commissioning Board, based on the outcomes they deliver for patients and good financial performance. But the consortiums’ commissioning budgets will never be diverted from patient care. Any surplus cannot be used to line GP’s pockets.”

First, I thought that the hon. Lady had not read the Bill or did not understand it. That would be one explanation. The Bill clearly allows for it. The payment is for performance; it is not about the quality and outcomes framework or the contracts but about commissioning performance, and nothing in the Bill would prevent a bonus payment from the board from going directly to GPs. The measure states that the consortium can distribute the payment “among its members in such proportion as it considers appropriate.” I carefully reread that letter to The Guardian, and the Minister’s words seemed quite specific. She said that GPs will not be able to “pocket any money not used from their allocated budget”.

This is not about money from the allocated budget, however, but a bonus payment given to GPs by the board. The Government may or may not prevent GPs from pocketing money from the budgets allocated at the beginning of the year for the purposes of commissioning. The letter does not, however, mention the end-of-year performance-related bonus payment that the board can issue according to the Bill. There is nothing to prevent that money from being distributed as members of the consortium see fit.

It is unacceptable to allow taxpayers’ money to go directly into the pay packets of GPs without any scrutiny. The measure leaves it to them to decide whether to put that money back into patient care when the NHS is facing the biggest financial challenge of its life, services are being cut, staff are losing their jobs, and waiting lists and waiting times are rising.

The Minister of State, Department of Health (Paul Burstow): Will the hon. Lady table amendments in future to prevent quality and outcomes framework payments? QOF payments are equivalent to these payments in that they provide an incentive for the effective provision of service, as these do for effective commissioning to achieve the best possible results for patients.

Liz Kendall: I will focus on amendment 215. Unfortunately, Labour Members are not in government—yet—and we are concerned about the Government’s proposals on performance-related bonuses.

Grahame M. Morris: It seems that there is a reluctance to use the term bonus, but if it walks like a duck and quacks like a duck, surely it is a duck. The provisions under new section 223L are for payments to a consortium in respect of performance. Does that come within the financial envelope of a consortium’s performance or is it to improve outcomes?

Liz Kendall: The payment relates to the commissioning performance of the consortium as a whole, not the clinical decisions of individual GPs. I am willing to discuss QOF, either on the Floor of the House or in Committee, but the amendment relates to a specific and large section of the Bill that allows an end-of-year financial payment for consortia that have “performed well”, whatever that means. There is no requirement for such a payment to go back into patient care.

Paul Burstow: I want to be absolutely clear, because it helps us understand the intention behind the amendment. The hon. Lady has described the current financial constraints that she believes the NHS to be under, although, given that the Government have provided it with additional real-terms increases, that is not true. Is she saying that under such circumstances QOF should be suspended or abandoned altogether, or that that is okay, but this payment is not?

Liz Kendall: I am saying that this part of the clause is not something that Opposition Members in this Committee are in favour of. We do not want to see an end-of-year bonus payment to consortia that they can distribute as they wish among their members, which could go into the pay packets of GPs.

Owen Smith: Does my hon. Friend agree that there is a fundamental difference between the QOF system and the provision? Under QOF, GPs receive additional funds related to specific clinical targets to be achieved in their patient population; the provision relates to a woolly notion of improving quality. The critical difference is the financial management that will drive in this instance the improvement or otherwise and the bonus culture that will stem from it.

Liz Kendall: My hon. Friend makes the point far better than I could—that is, indeed, my specific concern. I remind hon. Members on both sides of the Committee why some GPs, but not all, are concerned about bonus payments.
6 pm

Dr Clare Gerada’s concern is that patients may start to doubt the reason why GPs are making decisions. For example, if a GP has a new car, will patients think that that is because the GP has received a performance-related bonus payment? She is rightly concerned that some patients may worry that clinicians will make decisions on the basis of benefiting themselves personally and not their patients.

Dr Poulter: Does the hon. Lady think it right to incentivise GPs to weigh patients, fake statistics about smoking and so on—that is what happens now, and GPs are paid bonuses for that—or should they be incentivised by results, as the Bill indicates?

Liz Kendall: I believe that what is right is that any incentives for GPs and any payments they receive should be put back into patient care and not go into the pockets of individual GPs, which is what this part of the Bill may allow. The hon. Gentleman’s own Minister, the Under-Secretary of State for Health, the hon. Member for Guildford, said that “there is no way GPs will be able to pocket any money…consortiums’ commissioning budgets will never be diverted from patient care. Any surplus cannot be used to line GPs’ pockets.”

I am referring to the hon. Gentleman’s Government’s intentions and claims. The Bill does not prevent that from happening. It allows annual performance-related payments, and Opposition Members are very concerned about that, which is why we have tabled the amendment to delete the provision.

John Pugh: If someone is fortunate enough to have a commissioning body that commissions wisely, there may be a benefit or bonus from the Government. That seems to be the thrust of the measure. If someone is unfortunate enough to live in an area where commissioning is unwise, ineffectual or badly done, for whatever reason and perhaps without fault, it seems that there will not be additional benefits. The implication is that if someone is in an area where the commissioners are not performing well, patients will have fewer resources for their care. That is the logical outcome. Clearly, the thinking behind that—there is appreciable thinking behind it—is that the technique of maintaining the status quo for ineffectual commissioning bodies and rewarding the good ones will improve commissioning or raise commissioning standards.

I am a little concerned about people who are unfortunately endowed with poor commissioners who learn slowly, because they will receive fewer resources for their health in contrast with people who are fortunate in having proficient commissioners in their area, particularly as I suspect that the bonus money will be top-sliced generally from PCT funds. That is what Government’s characteristically do. The thrust of the measure is clearly to put in place a mechanism to improve commissioning, and the Bill contains a variety of mechanisms designed for that end.

Peer pressure is important and everyone will know the different performances of different commissioning bodies. It will bring the better ones into focus and, I hope, the worst ones into line. There is a strong element of public accountability, which will presumably improve commissioning, and there is a strong element of transparency, which will also improve commissioning.

My concern is about what future Secretaries of State, perhaps of a different political persuasion, may do. We are putting in place a tool for a future NHS commissioning body to micro-manage the local health service by simply defining what it thinks is good commissioning and the rewards that are attached to that and in that way persuade it to do things that it otherwise would not do.

A classic example would be this: if Lord Darzi were chair of the NHS commissioning board he would undoubtedly think very good commissioning would be to endow every area as far as possible with a Darzi clinic. He would regard that as major progress in commissioning. Certainly in my own area he has told the PCT that and I have two, not completely useless, but largely empty Darzi clinics as a result. We are not just talking about Secretaries of State who are prone to interfere in local commissioning decisions but people running the commissioning board who may be persuaded along the same lines. We do not know that they will not do that and we do not know that they will not be able to use this clause to micro-manage the local NHS.

I am not in principle against the idea of using some bonus system to reward commissioning if some of my doubts could be allayed. Will this be a tool that will improve commissioning because that could surely be the only justification for it? I hope the Minister will tell us in a minute what the evidence base is for suggesting that this would be a major step forward. I am sure that the Government would not have proposed something like this without looking for some evidence from around the world to show that public bodies rewarded in this way perform better. If he has that evidence and can share it with the Committee we would obviously be much more assured.

Mr Burns: Perhaps I can help the hon. Gentleman. The example is nearer to home than abroad and it is the operation of QOF.

John Pugh: That brings me on to the next point. The redeeming feature of the Government’s proposal was that it would exclude the reward of individual GPs because that is where the difficulties start. We need clarity from Ministers, not in terms of what they write to the papers but in terms of what the Bill means to them. There is a fundamental difference. It is intellectually unsustainable to compare QOF with what is proposed here. As I understand QOF, it is awarded by the Government for clear clinical outcomes. That is what QOF is all about. There is no other basis on which QOF is given.

Dan Byles (North Warwickshire) (Con): My understanding is that it is awarded for clear clinical processes rather than clear clinical outcomes. It is fundamentally different.
John Pugh: We could tweak it so that it is outcomes rather than processes. None the less it is a Government reward for specific performance. What we have here is the possibility of a commissioning body deciding for itself what it will reward. That is fundamentally different from QOF. We should not persist in comparing the two. If the Minister can present me with clear empirical evidence from across the world that this sort of incentivisation improves public bodies I will be much more reassured. He should also drop the comparison between QOF and what is happening here, because there is this fundamental difference between the Government deciding on the size of a bonus and the recipient deciding that.

Dan Byles: I have two brief points to make. First, I have sat on the board of an NHS trust in the west midlands. I used to have interesting conversations with the HR director. Every month she would say that the trust was struggling to get more than 60% of its annual mandatory appraisals done. I used to tell her that they must have a different definition of mandatory from the one we used to use in the Army. At one point I asked her what difference the annual appraisals made. If someone in a ward was doing a really good job that was above and beyond the call of duty and someone doing the same job in a neighbouring ward was doing the absolute minimum, was there any difference if one got a good annual appraisal and the other got a bad one. Did it affect their pay, promotions—anything? She said that no, these annual appraisals do not make the slightest difference. So it is no wonder that we struggle to get more than 60% of our mandatory appraisals done. I think it is the exact same issue that we are dealing with here.

Secondly, another example of a very similar system in place in the NHS is the clinical excellence awards, whereby secondary care consultants are given cash bonuses based on their performance as clinicians in the hospital over the year.

Owen Smith: The Minister said earlier that he thought the spirit of transparency and accountability was right at the heart of the Bill. He has an opportunity in response to this debate to illuminate this particular clause, which I contend is one of the more opaque in the Bill. The opening paragraph says in essence that the board may give bonuses based on performance as it sees fit, and the closing paragraph says that the consortium may determine how that money is spread out between its various members. Between the two there is a gaping chasm—a void in terms of detail—as to how that bonus ought to be calculated.

Over the last 10 minutes or so we have heard—if I may say so—a completely erroneous comparison between this and QOF. As several Members have said, QOF is a very different beast, whereby individual GPs are paid for performance against a very clear set of criteria. There are publically published objectives, some of which might be deemed inputs or processes, but others—for example, identifying patients at cardiac risk and treating them with a statin—very clearly lead to treatment outcomes. There is a world of difference between that and saying, as we see under new section 14Z1 of the 2006 Act, that the consortium must improve continually in terms of the quality of the health service they provide, and operate effectively financially.

I know of no walk of life—I have worked both in business and the public sector—where nobody would be set such flimsy and opaque objectives as improving quality and operating effectively financially. I welcome the Minister's suggestion earlier that there may be a further iteration of this whereby we will see more of the detail of the objectives. Frankly though, I have looked at them and spoken with colleagues on the Treasury Committee, and I think that Bob Diamond's bonus structure is a bit more robust, transparent, and straightforward than what we have before us in the Bill. Mentioning Bob Diamond is not facetious or outlandish—it makes a point. This is about introducing a bonus culture into the NHS, transplanted from the City to the surgery. It is at odds with the ethos of the NHS.

Dr Poulter: The point, though, is that this already exists; it was brought in by the previous Government. We have heard from my hon. Friend the Member for North Warwickshire about the clinical excellence awards, where consultants are paid a cash bonus for good service, so how can he stand there and try to re-write history?

Owen Smith: With the greatest respect, it does not happen at anything like the scale or in anything like the context or sense that is proposed in the Bill. QOF is an erroneous analogy—[Interruption.]

The Chair: Order. I remind the hon. Member for Broxtowe that she should be setting an example, being a Parliamentary Private Secretary.

Owen Smith: QOF is an erroneous analogy, as is the example we heard a moment ago in respect of secondary care physicians receiving individual bonuses. The difference here is that we will have a system whereby—as we heard earlier—commissioning consortia are potentially commissioning care from their pals or themselves, and then getting paid a bonus predicated on how well they or their pals perform in delivering that care or managing their budget. That is totally at odds with the ethos of the NHS. It is a step backwards, prior to 1948. It has shades of the era before the NHS, when we had the buying and selling of GP practices, and the Minister must look again at the clause. I fully support the amendment. We should strike out the clause entirely from the Bill.

6.15 pm

Mr Burns: We have had an interesting debate although I am not quite sure how illuminating it has been. However, I have come to the conclusion that, regardless of what I or my hon. Friends might say, there will not be consensus on this issue. With that as the background, I will now continue.

The amendment would remove the basic powers needed to allow the board to make payments to consortia dependent upon outcomes and thus would remove a key incentive—not a bonus, but an incentive—in the system for improving quality. Our plans place quality and efficiency at the centre of the NHS, by cutting bureaucracy and shifting decision making closer to patients through GP commissioning. Quality is the cornerstone of the Bill, with a duty regarding quality improvement placed on the Secretary of State, the NHS commissioning board and GP consortia. The clause is a
key part of that policy, as it enables the NHS commissioning board to make payments to GP consortia for their performance. In particular, GP consortia will be rewarded for how successfully they focus their resources to achieve better health outcomes for patients.

GP practices already make a key contribution to the overall quality of patient care and to the effective use of NHS resources. Coming together in consortia to commission health care on behalf of patients will empower them to collaborate more effectively in pursuit of high-quality outcomes for patients. Our proposal is that the board—not the consortia, but the board—should be able to make payments to consortia, to recognise the outcomes that their members achieve collaboratively through commissioning and the effectiveness with which they manage financial resources.

We propose that this quality premium should be paid in the first instance to a consortium and that it would be free to decide how best to apportion it between its member practices, to recognise the contribution that they make to achieving the common goals. The quality premium will be funded from existing resources. It will quite clearly be separate from the payments to GP practices for providing primary medical services. I hope that hon. Members have taken that point on board, because it is critical and I will just repeat it briefly. The quality premium will be funded from existing resources. It will quite clearly be separate from the payments to GP practices for providing primary medical services.

Some members of the medical profession have expressed concerns about the quality premium, contending that they fear it will come from their current pay and that it will put pressure on them to ration care to patients to ensure that they remain in budget. However, it is not the purpose of the policy to reward GPs for withholding treatment. Instead, what we are proposing is that GP consortia will be rewarded for using their resources to achieve high-quality health outcomes for patients.

A number of respondents to the consultation on commissioning, including a number of GPs, recognised that there will always be a cash limit in a tax-funded health system such as the NHS and therefore it is better to have decisions about how best to spend local resources made by local clinicians, and that there should be clear incentives for optimising the use of those cash-limited resources.

We fully recognise the need for care in designing the quality premium and in deciding how the combination of outcome measures and financial performance should be used to determine payment. Care will also be needed in deciding how the quality premium should be funded.

Making the most effective use of resources is not a completely new responsibility for GPs. The General Medical Council’s good medical practice guidance makes it clear that a good GP practice will make the most effective use of available resources to improve the population’s health and general well-being. This includes minimising waste in prescribing and reducing the use of ineffective treatments. It also involves engaging effectively in the prevention of ill health, to avoid the need for costly treatments.

Final decisions have not yet been made on the design of the quality premium. We will be discussing further with the profession how to ensure the right incentives for GPs to make the right clinical judgments for individual patients.

Derek Twigg: I know what the answer will be, but I want to ask the Minister a question for the record. I understand his last point, on continuing preparations for the premium, but can the Minister give the Committee any idea of the proportion of the budget that will be allocated to it?

Mr Burns: The narrow answer is no. As I said before I gave way to the hon. Gentleman, we have still to reach the stage of discussing the matter further with the profession.

What I do want to put on the record, to reiterate one point, is that the money will not be coming out of the budget for the commissioning of health care for patients. That is crucial to have on the record and to be understood.

Derek Twigg: I understand to an extent, but I find it strange that the Government have brought a Bill here. We are talking about £80 billion of NHS money being handed over to consortia, but the Government have no idea what sort of figure they might use for the premium.

Mr Burns: I do not share the hon. Gentleman’s view. This is a concept, an idea, and something we want to work out with stakeholders. As I have said twice, we will have further discussions on the design of the quality premium and how it will be implemented. To give chapter and verse of how it would work and exactly how much it will cost is not feasible or viable, because we have not got that far in our discussions. That is a perfectly reasonable position and, if we were not in it, and I was announcing figures before the conclusion of discussions with stakeholders who have an interest in the area, he would make the criticism, with some justification, that we were rushing in without sufficient thought or that stakeholder agreement.

On that basis, and with my reassurances, I hope that the hon. Member for Leicester West will consider withdrawing her amendment.

Liz Kendall: Those were vigorous if not particularly convincing comments from the Minister.

I want to go through a few points made by Members. The hon. Member for Southport, as ever, hit the nail on the head when he asked where the evidence base was for providing a bonus not to individual clinicians but to a commissioning consortium or whatever body commissions services. Where is the evidence that that improves the quality of health? He reminded me that much of the evidence is from the United States and suggests that one of the most powerful drivers of change is what is called peer-to-peer review—clinicians looking at, scrutinising and supporting the work of one another. That goes on within an organisation, and it is the relationships that are built and the degree to which people have respect for each other’s professional capacities, are working towards a common goal, and can challenge and support each other that drive quality, rather than, necessarily, the influences from outside an organisation. I thank him for making that point.

I am sure we do not want to reopen the discussion, but I thank my hon. Friend the Member for Pontypridd for making the important point about the difference between payments to individual clinicians in secondary
or primary care for their working decisions, and paying a commissioning consortium. We shall probably disagree about whether such comparisons can be made, but my hon. Friend was right to point that out.

I want to pick up on a point made by the hon. Member for North Warwickshire. QOF is not perfect, but he said that this is about processes and not outcomes. The hon. Gentleman may not remember the debate on clause 2 when we talked about quality. Most people who have looked at quality in health care say that a combination of the two things is needed. There are not always all the outcome measures that one might want, and some process measures are required. QOF could perhaps move towards outcomes, but we do not have the data for a lot of the information, and we must measure what we can.

This section of Bill is unclear. There has not been sufficient debate on the evidence for whether it will achieve its goals, and we are not clear about the pot of money, which is somewhat separate to that going out to GPs. Where is it? How much is it? Does it sit in the Department? How will it be shared out? Crucially, nothing in the Bill prevents that money going into the pay packets of individual GPs. Some do not want that to happen as they are concerned it will undermine trust. As the Minister has said, people do not want bonus payments that go back into the pockets of GPs, but the Bill does not prevent that from happening.

Question put, That the amendment be made.

The Committee divided: Ayes 12, Noes 12.

Division No. 30

AYES
Abrahams, Debbie
Burns, Mr Steve
Burston, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
Shannon, Jim

NOES
Brine, Mr Steve
Burns, Mr Simon
Burston, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

AYES
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES
Smith, Owen
Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.
Clause 28 ordered to stand part of the Bill.

Clause 29

Abolition of Primary Care Trusts

Question put, That the clause stand part of the Bill.
The Committee divided: Ayes 12, Noes 11.

Division No. 32

AYES
Brine, Mr Steve
Burns, Mr Simon
Burston, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
Shannon, Jim

NOES
Abrahams, Debbie
Barron, Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

Question accordingly agreed to.
Clause 29 ordered to stand part of the Bill.
Clauses 30 to 37 ordered to stand part of the Bill.

Clause 38

Role of the Board and consortia in respect of emergencies

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

Liz Kendall: I am sorry to start this debate so late in the day and hope that hon. Members’ energy and vigour will help them bear with me a little longer. The clause raises an important set of issues. I speak as a former director of the Ambulance Service Network.

Clauses 38 and 39 relate to the role of the board and consortia in respect of emergencies. I am concerned about where responsibility will lie under the proposals
for dealing with what the NHS calls emergency planning or emergency preparedness. Currently, strategic health authorities are responsible for co-ordinating the NHS’s response to major incidents, such as the 7/7 terrorist bombings in London, swine flu and major incidents of flooding. The strategic health authority is the main accountable body, but it works in co-operation with the ambulance services and the Health Protection Agency, which is being abolished and its responsibilities moved to the new national body, Public Health England. SHAs can delegate that responsibility if and when they see fit. For example, during the 2007 floods, the SHA delegated responsibility for the NHS’s response in the west midlands to the West Midlands ambulance service, which had the gold command in its headquarters. There is, therefore, some flexibility in the current system.

As the Minister has mentioned, I was an adviser in the Department of Health when the 7/7 bombings happened and, as I have said, I am a former director of the Ambulance Service Network and have discussed, seen and been involved in some of the exercises run within the NHS to make sure that the service is prepared for major incidents. I am sure I do not need to remind Members that threats and risks remain high in relation to terrorist activity, and that there was recently another bout of swine flu. Members in many parts of the country, such as East Anglia, will be concerned about flooding and other incidents. The issue affects us.

My concern about the Bill is, when SHAs go, where will their responsibility for emergency planning or preparedness lie? There are real concerns that, if it lies with a national board, which is going to be in Leeds, I think, how will they have the people on the ground who know all the local players within the NHS—be they the GPs or the hospitals—to bring them together and co-ordinate them effectively through the gold command structure? The NHS also needs a clearly defined person in that particular area to lead work with the police, local authorities and fire services. We need someone to have that responsibility, to know the key players, and to bring them around the table.

We also need someone who does what it says on the tin—emergency planning—who plans and runs scenarios, and who goes through the different things that might happen when there is a serious incident. Colleagues in the ambulance service tell me that they are not sure about where responsibility lies as a result of the Bill. It is said, simply, that the board will co-ordinate it with GP consortia. Many GPs are wonderful, but to make them responsible not only for commissioning £80 billion-worth of NHS services, but for emergency planning over the next two years, is a serious issue.

If the Minister wanted to sort out this situation, the Bill could be amended. An amendment has not yet been tabled, and I am interested to see whether there is such a response. There is a regional body that knows how to do this stuff, and that is the ambulance service. I strongly urge the Minister to look in more detail at this matter. In the light of a national board in Leeds and new consortia that are not yet established, will the Minister reassure me about the PCT leads on emergency planning?—they exist now—and explain how that is all going to work? As my former colleagues have said to me, at best, the Bill is unclear and, at worst, a mess.

Mr Burns: I certainly will seek to give the hon. Lady reassurance. Before I get into the exact detail of the clause, let me briefly answer her pertinent question about what is happening now, because that will be of use to her and it will be useful to have it on the record.

As the hon. Lady will accept, it is crucial to have effective emergency preparedness for any eventuality. The Department of Health is fully aware of the problems and concerns, and it is determined to ensure that there are proper, seamless and continuous plans in place during the transition of the modernisation plan. At present, the Department of Health is working with NHS emergency preparedness delivery partners such as the ambulance trusts, and through the strategic health authority emergency planning leads, to ensure that all emergency preparedness teams and functions are maintained at a high level throughout the transition programme. I hope that that reassures the hon. Lady, particularly given her experience in the ambulance service.

Liz Kendall: That is not a reassurance to me. Will the Minister write to me setting out what is happening now with the PCT clusters, whether they have an emergency planning lead and whether the pathfinder GP consortia have an emergency planning lead? If an incident happens across a region of London and if a board does not have a regional body, who does the co-ordinating? I understand that the Minister may not be able to respond now, but will he write to me on those points, because it is not clear from the Bill who takes that responsibility or how?

Mr Burns: Certainly; nothing would give me greater pleasure than to write to the hon. Lady and I will do that. In my defence, I was just dealing with the situation at the moment to reassure her that there was not going to be any hiatus or confusion during the transition. Although I say it myself, I thought I gave a fairly comprehensive answer on what is happening, but I will not dwell on that. I will certainly write to the hon. Lady as soon as possible so that she can have that information on paper. That deals with that, so I will quit while I am ahead and go back to clause 38. I will be brief, if that is for the convenience of the Committee.

6.45 pm

The provisions in the clause ensure that the new NHS is adequately prepared to respond to emergencies. There will be clear requirements on NHS bodies and all providers of NHS services to be prepared, and clear duties and responsibilities to ensure compliance with those requirements. The clause confers duties on the board and each consortium to ensure that they are properly prepared for emergencies that might affect them. Similar
duties will be imposed on each provider of NHS services as a term of the contract with the board or the consortia to provide services. The clause requires the board to take steps to monitor compliance by each commissioning consortium with its duty to be properly prepared for emergencies. The board will also be required to ensure that providers of NHS services comply with contractual requirements that they are properly prepared for an emergency that might affect them. The clause allows the board to co-ordinate NHS bodies' responses to emergencies that affect them.

The clause also allows the board to delegate the exercise of its functions in respect of securing preparedness to another body or person, and ensures that service providers appoint someone to ensure that the provider complies with its requirements for emergency preparedness. A relevant emergency for the purposes of the clause includes any emergency that might affect an NHS body or any provider of NHS services, either for the services that it provides or commissions, or in any other way.

I ask the Committee to agree that the clause should stand part of the Bill. As I said at the beginning, I give the hon. Lady an assurance that she will get a letter about exactly what is happening now and what will happen during the transition in the modernisation of the NHS.

Liz Kendall: I am afraid that I am no clearer about who is responsible for emergency planning in the NHS.

Mr Burns: At the moment?

Liz Kendall: I understand that the right hon. Gentleman has agreed to write to me about the transition arrangements, and I look forward to receiving his letter, but I am concerned about the future. Anyone who has experience of such situations knows that what is needed is one person with a clear line of accountability. I do not believe that he has answered the question.

Mr Burns: Is the hon. Lady talking about now, as we stand here? If so, it is the Department of Health. If is she asking who will be responsible in the modernised NHS, it will be the national commissioning board, working with others.

Liz Kendall: The Minister has kindly said that he will write to me about the transition. I am not asking about now, although PCT clusters and GP pathfinders are already set up. I would like to find out about the transition.

It is unclear how the board will work with consortia in the new world, which some of us may not wish to see. At present, the responsibility lies with strategic health authorities. Having the responsibility lie between the national board and GP consortia is no good in the case of an emergency. I seek further clarification of the matter. I shall not push clause stand part to a vote, but we would like to return to the issue later.

Dan Byles: I am listening to the hon. Lady with great interest. Not only was I a soldier in the Royal Army Medical Corps, where I was responsible for emergency medical support for NATO soldiers on operations, but I sat on the board of a mental health trust as a non-executive director with the lead for emergency response planning, so this is an area in which I take a close interest. She is right to highlight this important issue, but once again, she is obsessing a bit too much about structures. I am sorry, Mr Hood, I am not making a speech—I realise that this is an intervention. The board that I sat on had multiple links with multiple trusts, the PCT, the SHA and the acute trusts, and it worked, as long as people pulled together and knew what they had to do.

The Chair: Order. The hon. Gentleman is entitled to make a speech. We are on a stand part debate.

Liz Kendall: I am grateful to the hon. Member for North Warwickshire for his intervention-cum-speech—either is fine by me. I am grateful to him for sharing his experience. Of course, currently, there are multiple responsibilities and people have to work together, but there is a body that clearly has the ultimate responsibility and calls people together. During an emergency incident, gold command is in its headquarters, which is where people go. My concern is not that there are multiple responsibilities and people involved; it is about who is accountable, who people go to and who organises the gold command. That is not clear in the Bill. That is a concern, but I think it can be worked through.

Jim Shannon (Strangford) (DUP): In Northern Ireland, there is a senior officer from each of the councils across the Province who is the person who co-ordinates emergency planning and the response to incidents. Perhaps the hon. Lady wishes to ensure that there is one person handling the situation, rather than a whole body of people, which becomes confusing.

Liz Kendall: I thank the hon. Gentleman for that intervention. I value his experience and knowledge on the issue. Responsibility for emergency planning and leading during an incident cannot somehow lie at board or local level.

Dan Byles: I cannot imagine any circumstances in which that would happen. Right now it does not tend to be the strategic health authorities that lead; often, the emergency response facility in the local authority takes on gold command and the lead when an incident happens. As long as the commissioning board delegates the responsibility to a suitable, appropriate, recognised and nominated person, it will work. The hon. Lady is trying to micro-manage what that structure will look like from Government level.

Liz Kendall: I am not seeking to micro-manage. I am seeking to probe and raise serious questions that have not sprung out of my mind but come from talking to senior people with whom I used to be closely involved when working with the ambulance service. If they raise those issues with me, I feel it is only right and proper to bring them up Committee. I would not be doing my duty as an MP for my constituents or as a member of the Opposition Front-Bench team if I did not. I do not want to put the issue to the vote but I think it needs further scrutiny and we will bring the matter back on
Mr Barron: It is not my intention to delay the Committee, but I want to probe the impact of the clause in practice. As I said earlier, I chair the all-party group on pharmacy—I declare that because the clause deals with pharmaceutical services expenditure. The Minister will tell us whether my interpretation of the clause is correct, but I am concerned about new schedule 12A to the 2006 Act, mentioned in new section 165A(3), which the clause inserts. The explanatory notes state:

“Paragraph 2(3) requires the Board to notify each commissioning consortium of its determination of the designated elements of pharmaceutical remuneration on which the apportionment to consortia during the financial year is based.”

There are different elements, and I will not go into that, but the explanatory notes later state that

“Paragraph 2(5) provides that the Board may, in particular, take into account the financial consequences of the prescriptions issued by members of each consortium.”

That sounds to me as though the clause gives the board powers effectively to cap the amount of expenditure that each consortium can make on prescribing drugs.

The explanatory notes continue:

“Paragraph 2(6) provides that the Board may deduct the amount of pharmaceutical remuneration it has apportioned to a consortium from the sums it would otherwise pay to the consortium under section 223H and where it does so it must notify the consortium.”

That sounds like the board has powers both to set how much consortia will expend on pharmaceuticals, and to claim money back from consortia if the board thinks that they pay more than they should. That flies in the face of all that we have heard about bringing decision making nearer to patients. It flies in the face of what people have been arguing, both before and after the election, about how we should be looking not at the cost of new drugs, but at their effectiveness.

If my interpretation is correct—hopefully the Minister will get up and tell me that it is not—although I accept that consortia have a right to make sure that people are prescribing properly, are we really saying that we are going to set caps on what consortia can spend annually on different pharmaceutical services, including the cost of drugs? I see the Minister is shaking his head. He is going to tell me that my interpretation is wrong. If it is, perhaps he could tell me how he interprets the explanatory notes that I have just read out.

**Paul Burstow:** I thank the right hon. Gentleman for giving me the opportunity to put on the record what the clause does. It inserts new section 165A and schedule 12A into the 2006 Act to make further provision in respect of pharmaceutical remuneration. To go straight to the right hon. Gentleman’s key question on whether this is a device to be able to impose a cap on expenditure on drugs, the answer is emphatically no, it is not. The consortia will meet the cost of drugs from the overall budget that they are given. We had that discussion earlier about contingencies and so on. Hon. Members will be able refresh their memories when they go through Hansard.

Mr Barron: Will the Minister clarify what paragraph 3 of new section 12A means? It states:

“The Board may require a person to reimburse the Board for any pharmaceutical remuneration to which this paragraph applies if the drugs or services to which the remuneration relates were—(a) ordered by that person, or (b) ordered in the course of the delivery of a service arranged by that person.”

Why use the word “remuneration” if what the Minister just said is true?

**Paul Burstow:** I had hoped that I would not need to use the whole of my brief, but I will now do so because it is important to put it all on the record.

The clause inserts new section 165A and schedule 12A into the 2006 Act. Those provisions will govern the future arrangements for expenditure on NHS pharmaceutical services. It may help the Committee if I provide some background to the current system and the new arrangements.

Currently, qualified prescribers, such as GPs and practice nurses or qualified staff in hospital outpatient clinics, issue NHS prescriptions for dispensing in the community. Those prescriptions are usually dispensed by a community pharmacy, an appliance contractor or a dispensing doctor. The current funding arrangements allocate primary care trusts the whole of the budget for pharmaceutical services expenditure. That means that PCTs pay for both the costs of the pharmaceutical services provided, in terms of fees and allowances, and the costs of the products supplied against those prescriptions.

GP practices are, however, charged back the costs of the products they prescribe against a notional individual drugs budget allocation that the PCT notifies to them, so that GPs can monitor such costs. Currently, the relevant fees and allowances, and the amounts contractors will be reimbursed for the products supplied, are determined by the Secretary of State, following agreement between the Department and the Pharmaceutical Services Negotiating Committee. They are published each month in the “Drug Tariff”.

**7 pm**

I stress how important those determinations are. The price at which the NHS reimburses for products supplied is obviously of great importance to contractors, but the effects are much wider. The prices can impact on the
pharmaceutical supply chain, thereby affecting manufacturers and wholesalers. The prices are therefore extremely important in helping to maintain the stability of the supply chain as a whole.

The intention is that the Secretary of State will remain responsible for determining how much is paid for product reimbursement. The Secretary of State will also set the centrally determined fees and allowances that relate to the services element of the pharmaceutical services provision, but the board will meet the costs of pharmaceutical remuneration as a whole—both the remuneration for services and the reimbursement of the cost of the product. However, we expect that the board will want to charge commissioning consortia for elements of pharmaceutical service expenditure—for example, the costs of drugs supplied against GP prescriptions.

The new system will help those prescribers to be aware of the financial consequences of their prescribing decisions, just as they will take responsibility for the financial consequences of their referral decisions. That will provide incentives for a consortium to work with its practices to look at how to achieve the best overall health outcomes from the resources available, which was the point about internal peer pressure made earlier by my hon. Friend the Member for Southport. We expect that some product costs, such as the costs of the drugs dispensed against dentist prescriptions, will remain with the board and not be charged to GP consortia.

That is a summary of the current and future arrangements, which I hope is sufficient, although if the right hon. Member for Rother Valley would find it helpful, I can give further detail and clarification. As he has not indicated one way or the other, I will turn to the provisions in detail.

The clause will insert new section 165A into the 2006 Act. That will enable the Secretary of State to request whatever information he needs from the board about pharmaceutical remuneration, so that he can make informed decisions about the reimbursement prices that he will have to set, taking account of other expenditure.

The Secretary of State will be able to stipulate how and when that information is to be provided and what period it will cover. The clause will also insert new schedule 12A, which will make further provision regarding the detail of how pharmaceutical remuneration is to be dealt with by the board. I should make it clear that the term “drugs” includes not only medicines but appliances such as the products used to treat stoma care patients, and that “remuneration” covers all providers of pharmaceutical services.

Paragraph 2 of the new schedule will require the board to determine which elements of pharmaceutical remuneration are to be met by GP consortia and which by the board. The board must notify each consortium of what it is to be liable for in any financial year. For example, as I have previously explained, we expect that the board will want to make GP consortia responsible for meeting the cost of drugs prescribed by their members. Paragraph 2 will also enable the Secretary of State to direct the board about any specific elements of pharmaceutical remuneration that are not to be met by GP consortia. For example, that might cover the costs of NHS prescriptions written by other prescribers, such as staff in NHS foundation trusts or other service providers, including dentists.

In that way, we intend to ensure that the board will retain financial responsibility for those elements of pharmaceutical remuneration for which it is responsible, and that GP consortia are not charged for elements over which they have no influence. Given my original commitment to the right hon. Gentleman that that will not give the board powers to cap expenditure on drugs—the answer is definitely no—I hope that I have given him and other members of the Committee ample reassurance on, and a detailed description of, the clause.

Owen Smith: On a point of clarification, because I have either misunderstood or misheard, I thought that the Minister suggested a moment ago that the board will be responsible for the cost and will therefore, I presume, hold the budget to make payments for the cost of pharmaceutical products. That is what I thought he said a moment ago, and that seemed to be at odds with his final remarks, which were about GPs being responsible for meeting the cost of products in respect of the prescriptions that they make locally.

Paul Burstow: I suspect that the hon. Gentleman will benefit from reading Hansard rather than from me attempting to give another exposition.

The Bill will ensure that the arrangements used in the current architecture are reflected in the new system, with the difference being that the NHS commissioning board will hold both relevant budgets for that purpose. The board will also ensure that the GP commissioning consortia will be able to account for expenditure and provide information to their GPs about the cost of their prescribing activities.

Mr Barron: I am grateful for the Minister’s explanation, but why do the powers to reimburse under those circumstances allow one to take money off the consortia? As I understand schedule 12A, why is there that power if they retain the freedom that they have now, which the Minister suggested would be the case?

Paul Burstow: There is certainly no intention behind the Bill to enable a clawing-back of costs in the sense that the right hon. Gentleman is suggesting. I will reiterate to him the important point that there is no intention to place a cap in the way that he suggested in his original speech, and the Bill does not provide for that.

Owen Smith: I have a simple point. I take at face value the Minister’s statement that there is no intention to have a cap. However, does he accept that there will be a de facto cap if we have a centrally held and defined overall drug budget for the first time, as opposed to the current situation, where the amount of money spent on drugs is determined by the volume of prescriptions—and is therefore not controlled centrally and certainly not capped? If we have a centralised budget, we will effectively have a cap.

Paul Burstow: I return to what I said at the beginning. The current funding arrangements allocate PCTs the whole budget for pharmaceutical services expenditure. In that sense, there is already a budget. Through the Bill, we are trying to ensure that those things are clear in
the new framework and architecture. That is the basis on which the clause has been drafted. There is no sinister intent to remove from GPs their ability to prescribe and exercise their clinical judgment, which we intend to protect because we see it as critical to the way in which the NHS will operate in future. With that, I hope that the clause will stand part of the Bill.

*Question put and agreed to.*

Clause 43 accordingly ordered to stand part of the Bill.

Schedule 3 agreed to.

Clause 44 ordered to stand part of the Bill.

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**Clause 47**

FUNCTIONS IN RELATION TO BIOLOGICAL SUBSTANCES

Jim Shannon: I would like to ask a question of the Minister. I seek to make a point of clarification, not a long speech.

The Chair: Order. Does the hon. Gentleman wish to make a point of order? I will then be able to guide him.

Jim Shannon: On a point of order, Mr Hood. I would like a quick clarification on clause 47, which will make some changes to the Department of Health, Social Services and Public Safety in Northern Ireland. What will be the effect?

Forgive me for casting the net a wee bit wide, but I would like to get full clarification. Clause 46 will do away with the Health Protection Agency. Clause 47 refers to functions in relation to biological substances being exercised through the Secretary of State. Clause 48 refers to radiation protection functions. How does the Minister see the Department effecting control in Northern Ireland through this change and the clauses that have been put forward? At the same time, whether it is biological substances or radiation protection, they may be specific to Northern Ireland but they could carry to Scotland, England and Wales as well. Can the Minister clarify that, to put my mind at rest?

The Chair: What I invited the hon. Gentleman to make was a point of order, but that was not a point of order; it was a contribution—a worthwhile contribution. I invite the Minister to respond to it.

Paul Burstow: I am grateful for the hon. Gentleman’s question. The first thing to say is that clause 47 and several others around it ensure that functions that currently rest with the HPA are properly transferred and that the responsibility for discharging them is clear in the Bill.

On the specific changes in Northern Ireland, there have been discussions between the Department of Health and the devolved Administrations to ensure that they are satisfied with those changes, as with any changes that affect them. In addition to that, to ensure that the hon. Gentleman’s mind is fully settled and satisfied, I will write with any further details that may be of assistance in answering his question.

*Clauses 47 ordered to stand part of the Bill.*

Clauses 48 and 49 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned.

—(Stephen Crabb.)

7.12 pm

*Adjourned till Thursday 10 March at Nine o’clock.*