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Written evidence reported to the House.

Clause 54 agreed to.

Clause 55, as amended, under consideration when the Committee adjourned till this day at One o’clock.
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Monday 21 March 2011

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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)
† 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

Thursday 17 March 2011

(Morning)

[MR MIKE HANCOCK in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 101 Office of the Children’s Commissioner
HS 102 Royal College of Physicians
HS 103 Managers in Partnership
HS 104 Health and Social Care Information Centre
HS 105 British Association for Counselling and Psychotherapy
HS 106 David H Smith
HS 107 Tony Plumridge

9 am

Derek Twigg (Halton) (Lab): On a point of order, Mr Hancock. On Tuesday, we had an interesting debate about competition law and European competition law. For the Opposition, that debate is crucial—it is also in the interest of the House—because the Bill will change the nature of the application of competition law to the national health service. There was, therefore, a lot of debate, and the matter was also raised yesterday during the Opposition day debate.

On Tuesday, the Minister, for whom I have a great deal of respect—and who I believe is correct on this—said:

“May I just explain this first? As NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition laws will increasingly become applicable.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 718.]

That seems pretty clear to me.

Yesterday, during the Opposition day debate on the health service, the Secretary of State intervened on the shadow Secretary of State to respond to the same points about European competition law:

“It is dead simple: the Health and Social Care Bill does not extend the application of EU competition law, or the application of domestic competition law.”—[Official Report, 16 March 2011; Vol. 525, c. 379.]

We need to know which is the case. I know the Minister is considering publishing legal advice on competition law; so he might want to say something about that, but, for the sake of our ability to scrutinise the Bill and make proper decisions about competition law, we need to know exactly what is the case in terms of EU competition law.

The Chair: I do not think that that is a point of order, but it is a point that the Minister might choose to clarify at some time. I draw the Committee’s attention to Mr Burns’s statement in the paragraph preceding that quoted by Mr Twigg:

“The Bill does not introduce any new competition law or extend the applicability of current UK and EU competition legislation.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 718.]

So there is some confusion—but, to be fair, Mr Burns clarified the position.

Mr Kevin Barron (Rother Valley) (Lab): Further to that point of order, Mr Hancock.

The Chair: There is no point of order. If you want to raise a new point of order, please do so.

Mr Barron: This is a completely new point of order. Sooner or later, this complete confusion needs to be addressed. I heard the Secretary of State on the Floor of the House last night, yet the White Paper—I brought this to the Committee’s attention on Tuesday afternoon—says—

The Minister of State, Department of Health (Mr Simon Burns): I am grateful to you, Mr Hancock, because I think it would be helpful to give a very short explanation to clarify the misunderstanding among Opposition Members.

First, there is no inconsistency between the Secretary of State and me. [Interruption.] If hon. Members listen very carefully, the message will sink in and become clear. The Bill does not extend the application of EU competition law or the application of domestic competition law; you referred to that in passing, Mr Hancock. The powers given to Monitor as a sector regulator are the same as those now available to the Office of Fair Trading. The Bill does not change the scope of competition law at all, and neither of us said that it did.

As NHS providers develop and begin to compete actively with other NHS providers, and with private and voluntary providers, UK and EU competition laws may increasingly become applicable. I hope that that has clarified the situation.

Derek Twigg: Further to that point of order, Mr Hancock.

The Chair: Order. There is no point of order, Mr Twigg.

Derek Twigg: On another point of order, Mr Hancock. The Minister has responded to a different issue. The issue is about how the law will become increasingly applicable to NHS services because of the Bill.

With respect, I understand that there is some difference between what the Secretary of State said yesterday and what the Minister said in Committee the other day. To be clear about the point of order, I should say that, as we have made clear, this legislation will become increasingly
applicable to health services, over and above what pertains today, because of the Bill. We would welcome an answer from the Minister on that point.

The Chair: I honestly think that ingenuity has no bounds when it comes to trying to get in points of order. That is not a point of order; it is a point of debate. We have two more weeks of Committee, and I am sure that there will be ample opportunity for hon. Members to seek clarification on that point. If that was the most exciting moment of today’s proceedings, we are all going to be pretty bored, so let us hope that we can move on to deal with the clause 54 stand part debate.

Grahame M. Morris (Easington) (Lab) rose—

The Chair: The Opposition are eager to make a point. Is it another point of order, or does it relate to the clause stand part debate?

Grahame M. Morris: On a point of order, Mr Hancock. On European competition law and whether it would apply, the Under-Secretary of State for Health, the hon. Member for Guildford (Anne Milton), in reply to a Westminster Hall debate, gave a response that was completely at odds with the assurance that the Minister has given.

The Chair: You are eager to follow a position similar to Mr Barron’s in trying to make that point. However, that is a point for debate, and further clauses—and Report or Third Reading, if necessary—offer an opportunity for that issue to be explored. In today’s proceedings, we should put it to rest. The points have been made, and the Minister has given his response. No matter how hard we try, we will not get any more blood out of that stone this morning.

Clause 54

MATTERS TO HAVE REGARD TO IN EXERCISE OF FUNCTIONS

9.7 am

Question (15 March) again proposed, That the clause stand part of the Bill.

Liz Kendall (Leicester West) (Lab): Thank you, Mr Hancock. It is always a pleasure to serve under your chairmanship, particularly because of your kind regard for the sustenance of hon. Members.

The Chair: I wish that you had not mentioned that, because I cannot see anything going on that should not be going on.

Liz Kendall: The odd caffeine-infused—

The Chair: I wish you would not keep talking about it.

Liz Kendall: You are setting a bit of a precedent. I am sorry for my attempts to spread modernisation and reform throughout the parliamentary Committee system. I am sure, however, that hon. Members on both sides of the Committee would support it.

We have had a wide-ranging debate about Monitor’s role and function. For the record, I will be returning to the issue not of the scope of competition law, but of the applicability of competition law to the NHS, which is the key issue. No one has said that the scope of competition law will be extended, but rather that its applicability to the NHS will be extended, because of the fundamental changes in the Bill. I shall return to that point under clauses 60 to 70, which relate specifically to those issues.

Mr Burns: Will the hon. Lady give way?

Liz Kendall: If the Minister wants to say more about that point, I am more than willing to listen.

Mr Burns: I have heard what the hon. Lady has said, and I just wanted to confirm that she will be happy if I respond to those points at that time, rather than now.

Liz Kendall: I absolutely will. It is important that we have a full discussion about the matter, but that is not appropriate under clause 54.

I want to make two main points about the clause, which are directly relevant here, but they lead to an overall concern about the Bill. First, clause 54 sets out a whole range of issues that Monitor must have regard to in exercising its general duties. Those include a duty to promote the economic, efficient and effective provision of health care services. We have also talked about its function to promote competition.

However, under clause 54, Monitor must also have regard to the desirability of securing continuous improvement in quality and efficiency, ensure fair access to services, and ensure that commissioners make best use of resources. It has to have regard to the desirability of promoting investment and the need to promote research and high standards in education and training with respect to health care.

I am sure that hon. Members agree that balancing those different issues is no easy task. There are inherent conflicts between the need to balance fair access with competition. Sometimes the one improves the other, sometimes not, depending on how the system works. With regard to balancing quality with efficiency, there is a lot of evidence to show that the two are linked, but there are also difficult trade-offs that inevitably have to be made. That brings us to the fundamental point. There are always trade-offs between trying to improve the quality of, and meet demand for, services—demand that, if not infinite, is increasing in the NHS and health care services across the world—while making the best use of finite resources.

That is an extraordinarily difficult task for Monitor. However, not only Monitor is involved in those difficult conflicts, balances and trade-offs; GP commissioning consortia also have to seek to strike those difficult balances. They have been told that they cannot go over budget. I have already raised issues about how difficult that would be, although it is a desirable goal. The NHS commissioning board also has the goal of trying to make the best use overall out of taxpayers’ money for the NHS, while securing all sorts of different improvements in quality and outcomes.

First, this is a very difficult issue. Secondly, the problem is that there are a number of different bodies charged with achieving the goal. My real concern is about where
the authority finally lies for making that difficult balance of decisions about what is the best use of taxpayers' resources to get the best possible outcome for patients.

I refer hon. Members to the helpful and thoughtful briefing from the King's Fund. I should mention at this point, as a declaration of interest on the record, that aeons ago I worked at the King's Fund. The King's Fund said about the measures in clauses 52 and 54—[Interruption.] I hope the Minister will listen because this is a difficult issue. I am, as always, trying helpfully to alert him to issues and problems—not to misrepresent the Bill, as the Minister was reported as saying in The Guardian.

The King's Fund said:

“These provisions do not make it clear how the balance between these various duties and considerations should be struck and how conflicts between Monitor's policies and those of the Care Quality Commission and NHS Commissioning Board, for example, should be resolved. The Bill does not adequately define the role of Monitor in relation to these bodies. For example, it does not make clear the circumstances determining whether the Secretary of State should turn to Monitor or the NHS Commissioning Board to deal with performance issues. Under the framework set out in the Bill, no single organisation is responsible for overseeing the NHS as a whole, in terms of both provision and commissioning.”

What it says next is interesting, as the Government are seeking to model the NHS along the same lines as the regulated utilities, railways and industry.

Mr Burns indicated dissent.

9.15 am

Liz Kendall: I do not know why the Minister is shaking his head, because the Bill states that it is based on precedence in those sectors. That is why I made a probably overlong speech on Tuesday trying to explain why the two systems are so fundamentally different and that a different system should apply. Interestingly, the King's Fund stated:

“In the case of the energy industry”

—and this is about who is ultimately responsible, or who has the overarching view of the system—

“This difficulty has been resolved in part by giving ministers powers to issue general directions relating to the policy framework within which the regulator should operate. However, these sectors have a much simpler governance structure and there are no equivalent bodies to the Care Quality Commission or the NHS Commissioning Board.”

In other words, with gas, electricity and telecoms, there is Ofgem and Ofcom, and that is it. There are no other bodies with responsibilities, as there are in the NHS. The King's Fund also states:

“In relation to specific trade-offs such as cost or access versus quality, other regulators have commissioned research from service users to help define where the balance should be struck. In one case, the water regulator asked ministers for a decision as the cost implications of implementing higher standards were so considerable.”

It is very unclear who takes the ultimate decision on the appropriate balance between efficiency and costs, and quality. In the regulatory systems, there is one body that does that, which is the economic regulator. Under the Government's plans, there will be Monitor, the Care Quality Commission, the NHS commissioning board and GP commissioning consortia. Will the Minister explain who is responsible for striking that trade-off, and how it will happen?

John Pugh (Southport) (LD): Mr Hancock, you missed the fun and games the other day, but I am sure you would have enjoyed them.

This is an opportunity for the Minister to be very helpful and clear up Members' concerns. As I listen to the debate, it seems that there are not vast gullets in terms of the objectives that people set themselves, via this set of clauses, but that there are vast differences in the policy outcomes that people foresee. This is a genuine attempt on my part, therefore, to get the Minister to convince those who are more sceptical than he is about how things will pan out.

We are in unknown territory, because there is no natural history for a regulator such as this. However, the natural history of existing regulators shows that when they have been created, they do not always have the effects that were anticipated. There has been criticism of regulators that Parliament has created and then regretted doing so. We are, in a sense, creating not a new feast—because Monitor is not a completely new feast—but a new mechanism.

The Minister was helpful in a previous sitting in pointing me to parallel examples of regulators in Germany and the Netherlands, and I have since researched that. I do not think, however, that those regulators have precisely the same role as the regulator we seek to put in place here. I could not find a regulator that has the job of promoting competition in Germany or the Netherlands, although I was unable to look at the situation in all parts of America, which he also specified.

In my initial remarks on this matter the other day, I did not ask whether the effect of creating Monitor would be good or bad. I questioned whether it was, in fact, necessary to have Monitor to achieve the effect that the Minister clearly wants, given that primary care trusts are already procuring a range of services in a relatively competitive health market. We have to accept, however, that the Minister and the Government are trying to achieve some of the crude effects that might be imposed by a pure economic regulator, and that is to be supported.

By and large, we know that regulators tend to regulate profit-driven industries, but we are creating an organisation that will regulate institutions that are presumably aimed at the public good. Most regulators that I have seen hitherto essentially accept the fact that there is a market out there driven by profit, and they seek to moderate that market to achieve a public good. We are, at any rate, doing something different, because we are trying to control a whole series of agencies—NHS agencies, in particular—that seem to be primarily motivated not by profit, but by public interest. Therefore there are problems.

What I am most interested in—the Minister can help me with this—is that the key thing about Monitor is that it can overrule commissioners or producers when they act anti-competitively. That is the fundamental thrust behind creating the body, but there is a series of mitigating factors in the clause to ensure that Monitor does not act in a crude or insensitive way.

During our discussions on a clause that we were debating the other day, the Labour party moved that Monitor should also be sensitive to integration and
collaboration, and the Minister ingeniously, but not particularly convincingly, tried to distinguish outcomes and processes. I do not want the Minister to comment on the solution, but will he give examples of how the provision will work in practice and the kind of progress that there will be through the system?

It seems that Monitor will not do a lot about uncompetitive behaviour by producers, provider organisations, which are, by and large, encouraged by the legislation to compete against one another. It is not clear what anti-competitive behaviour by provider organisations towards the NHS looks like; I know what competitive behaviour in the NHS will look like, and perhaps some of the unfortunate consequences will stem from that.

The only example of uncompetitive provider behaviour that I can think of is if a company such as Tesco decided to price its pharmacy products in such a way as to put local pharmacies out of business. That strikes me as fairly uncompetitive, but I do not think that Monitor’s remit would extend to Tesco. It would help if the Minister gave some examples of uncompetitive behaviour by providers, for which Monitor would show the red card.

It is easier to understand what uncompetitive commissioning looks like, and the Minister helpfully provided examples of that. The hon. Member for Stafford mentioned doctors in their surgeries worrying about whether they were referring someone to a provider without giving them sufficient indication of their options, or persistently recommending the same provider. That would clearly be perceived as uncompetitive behaviour, particularly if the options were not adequately disclosed to the patient.

The hon. Gentleman also mentioned objections to block contracts—with which I am familiar—when they are against patients’ interests. There is also the refusal to fund any willing provider, which is what I am most interested in. If a willing provider arrives in town wishing to provide a service and the commissioners refuse to commission it, even though patients are keen on using it, Monitor will, I imagine, intervene and show the red card.

Members who have heard me speak in the past will probably think that I am biased in favour of primary care trusts, but I am not. Primary care trusts in my part of the world have behaved in a wholly anti-competitive way, in one sense. The biggest single health issue in my constituency of Southport, stretching back more than 10 years, is that we do not have an A and E department or the paediatric department, in Ormskirk might become no longer sustainable. A shortage of paediatricians was the key issue, because they need a certain flow of patients—the fewer they got, the less sustainable the department was. It would have a ripple effect. It would have an effect on Ormskirk hospital, which would have an effect on the local networks in the area, which would have an effect on Alder Hey. One could say, “Well, so be it. This is driven by consumer interests from the bottom.” But one wonders who is going to sort out all the pieces.

I am more comfortable with the idea of resolving the problem by explaining to a democratic body of decision makers the options, the effects—according to the best professional advice—and what will fall on their heads as a result of their decisions, because they have to live with those decisions. The problem is that Monitor does not have to live with the decisions. It is a long way away, and right across the country it can make all sorts of decisions that have consequential effects.

We can live with that environment and tolerate it, but it is the local health economy rather than Monitor that has to live with it. It is a genuine concern that, if Monitor operates as I expect it to, there will be these effects right across the country.

**Emily Thornberry** (Islington South and Finsbury) (Lab): I am listening with great interest to the hon. Gentleman’s experiences and how they apply to the proposed legislation. His party’s policy used to be to have elected primary care trusts, which would presumably give the sorts of outcomes that he is asking for. How did his party move so far from that policy to supporting the Bill instead?

**The Chair:** I do not know whether that is relevant to the debate, and I urge Dr Pugh not to go down that route.

**John Pugh:** I always felt that a more modest proposal would be for whoever does the commissioning—the PCT or the commissioning consortium—to present a plan and let local people amend it, rather than for an elected body to construct a plan. That was always my favoured suggestion. We could move towards that situation in the Bill by letting the commissioning consortia answer
in a more direct way to health and well-being boards, which presumably will stick around to represent the local community in some ways, and which have to live with the consequences. There is a tension between what might be democratically acceptable and what Monitor might want to do.

**Liz Kendall:** This may sound like a philosophical point, but it is relevant to the debate. The hon. Gentleman is aware that David Bennett, the chairman of Monitor, has spoken about taking the politics out of the health service, and about decisions being based on fact and evidence rather than on politics. That presumes that politics is not based on fact and evidence, which I hope that it mostly—if not always—is.

**The Chair:** Order. My co-Chairman made the point on Tuesday that interventions should be short and to the point. Members should remember that. I hope, Ms Kendall, that you will not go too far down the philosophical route—we could write a book on this—but will ask Dr Pugh whatever you were going to ask him and move on.

**Liz Kendall:** My question was whether he believes that there should always be democratic accountability for decisions, or whether they can be moved to some kind of purely scientific or factual basis. Or is it more complicated?

9.30 am

**John Pugh:** I expect that it is more complicated. There is always tension between what people regard as clinically safe and what some of the population regard as desirable in terms of access. In my constituency, that has been the debate over this particular issue for the last 10 years. Committee members might be interested to know that the embryonic GP consortia asked about this outstanding democratic issue, which had people marching through the streets of Southport and has seen successive parliamentary campaigns. In 2005, a hospital campaigner stood against me on the failure to deliver this particular outcome. The GP consortia asked about it very recently, and they say not only that they are not offering a solution to it, but that it is not a problem.

The belief that GPs will somehow deliver something that is more democratically acceptable to the population is arguable. It does not seem evidenced in my own experience, which is what drives me here. The issue for the Minister, a genuine, serious concern—and I know that he is as anxious as I am to get this right—is how we can avoid Monitor’s making decisions on narrow grounds that ignore the overall effect on the health economy. Are these clauses sufficient to ensure that that is the outcome, given that Monitor does not have to live with outcomes?

I do not want to labour the point about European Commission directives and so on, because frankly I do not understand all the detail, but I am familiar with NHS procurement by provider organisations because my daughter works in that field. I know that it is governed by European competition law, as the Minister has said—OJEC regulations and so on. They are very laborious, bureaucratic and expensive to administer. To simplify it so that someone like me can understand, as I see it, the procurement of clinical services is not subject to that same set of rules.

I would like a very clear statement from the Minister that this legislation does not put in place the identical template system and set of rules in the commissioning of clinical services that currently applies to the procurement of beds, taxis, and all the other things currently procured by NHS bodies as standard.

**Owen Smith (Pontypridd) (Lab):** I do not want to make a long speech about this.

**Mr Burns:** Sure you don’t.

**Owen Smith:** No, I do not. However, there are a few things in clause 54 that I would like to point out. Picking up from the closing remarks made by the hon. Member for Southport, I think we do now have clarity in respect of competition. The Minister is right that there is no difference between what he said on Tuesday and what the Secretary of State for Health said yesterday.

The only difference was what the Secretary of State left out of his remarks, which is the crucial coda that the Minister gave us on Tuesday and repeated this morning: competition law is not changed by this Bill, but it will increasingly apply in and bite on the NHS as more entrants come into the market. In effect, as there is a more genuine open market, so too the safeguards or challenges that we see of competition legislation have to be applied to the NHS fairly and under the law, in a way that has not happened before.

Clinical services, hitherto insulated from competition law, will be increasingly affected by it in future. Increasingly, the same process as applies to bedpans—currently procured under competition law—will apply to clinical services.

**Dan Byles (North Warwickshire) (Con):** Does the hon. Gentleman think that under the plans that the Labour party put forward—for any willing provider and greater use of private care—the same would not have applied, had there been no change to the way the law applies to the NHS?

**Owen Smith:** Had what we intended to apply extended the volume of competition and the number of entrants, had we removed the crucial caveat that the NHS was the preferred provider and had we opened up competition to 95% of the NHS instead of the 5% where there was managed intervention, I imagine we would have seen competition law abiding. However, we did not do that. Only 5% of the NHS budget was ever in the hands of private providers.

**The Chair:** I urge the hon. Gentleman to come back to clause 54. Competition is not specifically mentioned in clause 54, and there are other clauses on which it will be more appropriate to make that speech.

**Owen Smith:** I respect your intervention, Mr Hancock, but the point I am trying to make is that the extent to which competition law will bite on the NHS absolutely impacts on the functions that Monitor has both to perform and have regard to under clause 54. As the
hon. Member for Southport was pointing out, it will impact on its ability to make holistic decisions—to think about the totality of the health care system and to try not to make decisions on narrow grounds. The sorts of forces that will dictate its making decisions on narrow grounds may well come about as a result of its having to have greater cognisance of competition law and the implications of competition law.

So I turn again to clause 54 and it is in that context that I challenge the notion about Monitor. The clause is interesting in that it is a list of “need to do” and “nice to do”, with desirability. Under the “need to do”—I assume this is really important; more important than the “nice to do” desirability provisions—there is the need to maintain patient safety. We would all accept that that is a crucial aspect of any duty in any facet of the NHS.

My concern here, which is an adjunct to the point that the hon. Member for Southport was making, is about how Monitor can be certain that it is making decisions in the best interests of patient safety if it is also having to give regard to value for money. Furthermore, and crucially, it is potentially being dictated to—over time, in the decisions that it has to take—by case law, competition law and the way in which it may become increasingly fearful of intervention in the courts by other actors in the health service who are looking to get a piece of the action of clinical service or pathway or local health economy x or y.

Derek Twigg: My hon. Friend’s point has not been expanded on too much in this Committee, although no doubt it will be under competition law. It is important. He is saying that there is a likelihood of not just providers but commissioners possibly challenging decisions in the courts. That has a massive potential to grow.

Owen Smith: I offer a hypothetical example—I am not as wary as the Minister about hypotheticals—to try to illustrate what I mean. I extend the point into one that I will make in a minute about research, because it holds fast for both issues. Take a medicine such as Lucentis, which was being used for age-related macular degeneration and around which there was an enormous row a couple of years ago. Was it the right medicine? Was it effective? It was certainly expensive. Should it be used? NICE was in a quandary about it.

We ended up with a postcode lottery of Lucentis being allowed, often under exceptional case rulings, in certain parts of the NHS and not in others. We also ended up with Lucentis effectively being discounted enormously in certain parts of the NHS, where they were keen to use it, and not in others. Age-related macular degeneration is an area where this sort of behaviour has happened in the NHS over a long period. There was a cohort study that saw different bits of the NHS as interested, perhaps through GP consortia, in the drug’s being delivered in primary care or secondary care, but other bits of the NHS were not.

Once competition law was applied, how would the NHS withstand a company or other actors through the courts insisting on all parts of the NHS using the medicine? How would NICE’s views on whether that medicine was safe and appropriate for all patients withstand a challenge in the courts? The Bill opens up all those questions if competition law bites, as we anticipate it might.

Any medicine that is controversial or being trialled in the NHS is interesting, because Monitor also has to have regard to the need to fund research in the NHS. I am sure that none of us would disagree with the fact that the NHS is potentially a hugely important global resource for research, as it has the largest total patient pool. For many years, Members on both sides of the House have wanted to realise fully the potential of the NHS as a vehicle for research.

One key problem we have with the Bill in terms of research—we heard about it in evidence—is that PCTs have in the past picked up the excess treatment costs associated with research, but there is no clarity in the Bill about who will pick up the bill for those costs. Will it be the GP consortia? We do not know. Will it be the ethereal regional presence of the NCB? We do not know. Will the drugs companies be forced to pick up those costs in future? It certainly will not be Monitor, so how can Monitor have regard to the desirability of promoting research? Is that not an entirely redundant duty to place on it?

Even if the duty is not redundant, it absolutely cannot be delivered by Monitor. There are many holes in the Bill in so many respects—and the more I look at it, the more I see vast chasms and worry about how on earth it can ever work.

John Pugh: I do not think the latter argument is a particularly good one—the rest of them are, of course, absolutely excellent. Presumably, in a commissioning decision, someone may commission something more expensive that has benefits for NHS research, so a viable case can be made for it, as opposed to commissioning something, perhaps in the private sector, that has no research element attached. In that way, the research imperative in the legislation could kick in and help make decisions.

Owen Smith: With respect, I think we are speaking at cross-purposes. Perhaps I did not explain myself carefully enough. The point I was trying to make is that there is always a cost associated with trialling a medicine in the NHS. Previously that cost was, essentially, met by PCTs. The NHS body that delivered and operationalised the trial with NHS patients did not have to bear extra costs as a result; they were picked up centrally. Nowhere in the Bill is it clear where that central cost will be met.

There is a further point about competition that is relevant here, and it is that dispensing doctors—

The Chair: We are going back to competition.

Owen Smith: I shall sit down, but I will come back to it.

The Chair: I am sure you will.

Mr Burns: I am looking forward to it.
The Chair: We are all looking forward to it.

Mr Burns: May I begin my response to the stand part debate by reiterating, particularly to the hon. Member for Leicester West, that health care cannot be delivered in an unbridled free market? Health is different. Patients require protection, and such a market would not guarantee that essential services would be delivered.

We had a similar debate last Tuesday, in which I made it clear, as I see from reading my comments, that we do not regard, never have regarded and do not intend to regard the health service as a utility or as having a role like Ofgem’s, Ofcom’s or whatever. However, if I stood here and said to my hon. Friends and Opposition Members that we had not looked at their regulatory procedures to see whether there was anything relevant or useful, we would be criticised for not doing so. I suspect that Opposition Members will criticise us whether we do or do not do that in any area, because that is the nature of the beast with respect to their opposition to the Bill.

9.45 am

The Chair: Order. May I ask hon. Members on both sides of the Committee to respect the fact that we are dealing with clause 54 stand part? We are coming back to the issue of competition. To be fair to Labour Members, you also, Mr Burns, have to limit your comments at this stage to what is relevant to clause 54 stand part and not widen the debate again. It would be unfair of me to stop some hon. Members doing that and then allow you to do so. I hope that we can all respect the fact that we are dealing with clause 54 alone at this stage.

Mr Burns: In the context of what I just said and the fact that we do accept that health care cannot be delivered in a completely free market, that is the reason why the Government want to introduce an economic regulator for health. The key purpose of economic regulation is to protect the interests of patients and taxpayers by protecting essential services and promoting efficiency, transparency and fairness in the way in which taxpayer funds are used.

Robust economic regulation will create certainty about prices, offer incentives for providers to thrive, facilitate the introduction of innovative services and safeguard essential services, which a free market cannot necessarily do. That is fundamental in our vision for putting patients and quality first. Monitor cannot deliver that in isolation. It will be part of a health care system. It must work with the commissioning board on pricing and with the Care Quality Commission on the licensing regime. It must also work within an overall context and give consideration to how its regulatory functions will impact on the wider system.

Clause 54 sets out the key considerations to which Monitor must have regard in carrying out its functions. Those will provide key safeguards, as well as giving Monitor a strategic framework in which to operate. The first key consideration to which Monitor must have regard is “the need to maintain the safety of people who use health care services”.

The second and third are the desirability of securing continuous improvement in the quality and efficiency of health care services provided for the NHS.

The clause goes on to provide that Monitor should have regard to certain considerations applying to commissioners: the need for commissioners to ensure that people who require NHS health care services have access to them; the need for commissioners to ensure that the provision of access operates fairly; and the need for commissioners to make the best use of resources.

The clause specifies that Monitor should have regard to the need to promote investment by providers of NHS health care services in those services. Monitor should also have regard to the need for those who provide health care services to the NHS to promote research into matters relevant to the NHS. The clause also provides for Monitor to take account of the need for high standards in the education and training of professionals who provide health care services to the NHS.

The final subsections of the clause are designed to help to ensure that Monitor works effectively with other parts of the system that will create the infrastructure for the provision of NHS health care services.

Derek Twigg: I am intrigued by Monitor’s involvement in the “best use” of resources. We have read about that in the Bill and the Minister has just reiterated it. The Government are saying in the Bill that they are freeing GPs and giving consortia freedoms. Clearly, they will make the best clinical decisions. Does the Minister not see that there might be a contradiction between what Monitor sees as the best use of resources and what a GP consortium sees as the best use of resources, or does he see no problem whatever in that respect?

Mr Burns: I do not think that there is any conflict at all in the way that the hon. Gentleman suggests. Everybody working in the NHS—now, in the past and in the future—will have regard to resources for the very simple fact that resources to the NHS are not unlimited, and we have to work within a budget.

Derek Twigg: It is easy to say that, but the big difference is that they have got to promote competition. Is the right hon. Gentleman seriously saying that there will be no conflict of interest whatever, that the system will work perfectly, and that there will be no disputes between GP consortia and what Monitor wants?

Mr Burns: I am not saying that per se, because of course we are operating on a slightly different premise for the simple reason—[Interruption. I have not finished, so the hon. Gentleman does not know what I am going to say. He cannot get it fixed squarely in his mind that we are talking about competition based on quality. He will hark back to that old argument, but I am not going to go down that route, because I know that you, Mr Hancock, will rightly, on clause 54, haul me up.

Liz Kendall:rose—

Mr Burns: No, I am not going to be tempted by the hon. Lady either because, as she will appreciate, we are discussing clause 54 and—
Liz Kendall: It is on clause 54 specifically.

Mr Burns: Okay.

Liz Kendall: It states specifically in clause 54 that Monitor has a duty “in exercising its functions,” to “promote the economic, efficient... provision of health... services.” So it is not just about quality—there are financial considerations coming into play. To say that Monitor is just acting on quality is simply not what it states in the legislation.

Mr Burns: The hon. Lady slightly anticipates—

The Chair: Order. I have to say that I cannot find those words in clause 54.

Liz Kendall: Subsection (3).

Mr Burns: The hon. Lady slightly anticipates me, because in the course of her remarks she asked me a number of questions that I will address when I have set the framework of the clause.

The clause goes on to make provision that Monitor should have regard to certain considerations that would apply to commissioners. The clause also specifies and provides for Monitor to take account of the need for high standards in education. The final subsections in the clause are to help ensure that Monitor works effectively with other parts of the system that will create the infrastructure for the provision of NHS health care services. Monitor would have to take account of the way in which the Secretary of State and the NHS commissioning board performed their relevant statutory duties. The clause is to ensure that, in its role as economic regulator, Monitor would work in a way that had regard to, and complemented, the roles and responsibilities of other key players in the system. I believe that it is right to leave it to Monitor to consider and balance those things. Independence will be key to Monitor’s role as an economic regulator, hence the requirement about “having regard to”, rather than them being absolutes. They are not in competition with one another. It is about balancing them in the best interests of patients.

The hon. Lady, in an interesting speech, raised a number of issues that I promised I would address. First of all, one thing that the hon. Lady seemed to be saying was that too many bodies are responsible for driving up quality. I have to say that quality is, as we keep mentioning during the course of these debates—

Liz Kendall: On that point.

Mr Burns: I have not actually started, but if it helps, I will give way.

Liz Kendall: I am sure that the right hon. Gentleman will see, when he looks at Hansard, that I did not say that there were too many bodies responsible for driving up quality. I said that there were too many bodies who are tasked with both trying to improve quality and delivering the efficient and effective use of resources. Several bodies are trying to balance those difficult considerations. The question I raised was: who is ultimately responsible?

Mr Burns: I know the hon. Lady is not a lawyer, but that did seem, in the nicest possible way, to be slightly splitting hairs. I will seek, however, to answer the bottom-line question, which was—unless I have misunderstood what the hon. Lady thinks—who exactly is responsible for driving up quality. Quality, as we keep mentioning during the course of these debates, is the guiding principle of the NHS, and we are, for the first time, making that a reality in primary legislation. That is why we have sought to ensure that all levels of the system have a role to play in driving up quality. That includes the need for Monitor to have regard to the need to secure continuous improvements and quality in the NHS.

Emily Thornberry: Will the Minister give way?

Mr Burns: No, may I just finish answering the hon. Member for Leicester West?

Ultimately, providers and clinicians are responsible for delivering high-quality care and are held to account, through contracts, by their commissioners. As now, the CQC’s role will be to safeguard essential levels of quality. It is the job of the commissioners to drive up quality and the job of providers to deliver care that is of much higher quality than set out in the essential standards. I hope that that answers the hon. Lady’s point.

Emily Thornberry: Given that Monitor has the ultimate responsibility for ensuring competition, many of us in the Committee would like to know who has the equivalent job of being the ultimate arbiter of quality. The CQC is sometimes quoted as being that body, but we all know that it will provide a basic safety net. I respectfully say to the right hon. Gentleman that it is simply not good enough for him to say, “Oh, it’s everybody’s responsibility to push up quality.” If we are talking about something as important as developing a market and competition, why is there not in this architecture one body that is ultimately responsible for defining and ensuring increases in quality?

Mr Burns: Oh, Lord. I really do not want to keep going round in circles.

Emily Thornberry: Given me an answer.

Mr Burns: If the hon. Lady will keep quiet, she might get the answer. In the context of answering the hon. Lady’s question, let me repeat once again for the record that we seek to ensure that all levels of the system have a role to play in driving up quality. As we have said in earlier debates, and I will say it again so that the hon. Lady will, I hope, finally twig, there is the commissioning board; there is the CQC; there is Monitor, which will carry out its duties as part of the jigsaw; there are the commissioners; there are patients, who can exercise patient choice; and there are the hospitals up and down this country. They will all work together to improve and
enhance quality and to achieve the other aim of our modernisation: to improve outcomes, which is of most importance to patients.

Emily Thornberry rose—

Mr Burns: I am not going to give way to the hon. Lady again, because I have now explained the issue.

Dan Byles rose—

Nick Smith: Will the Minister give way?

Mr Burns: Certainly not. I will give way to my hon. Friend.

Dan Byles: Does my right hon. Friend agree that without a quality tsar or commissar dictating health outcomes, the Labour party do not seem to understand how quality can be embedded?

Mr Burns: My hon. Friend is so right. New Labour the Opposition may have been, but they are, sadly, still in the straitjacket of the old Stalinist attitudes that drove the NHS through its early stages.

Emily Thornberry: Will the right hon. Gentleman give way?

Mr Burns: No. I now turn to another issue raised by the hon. Member for Leicester West, who suggested that Monitor’s functions might be in conflict. It is true that Monitor will need to balance a number of objectives, which may sometimes come into tension—hon. Members should listen carefully, because I do not want my words misinterpreted. That is why clause 55—we will come to that later—sets out a transparent process for managing conflicts between functions.

The hon. Member for Southport raised a number of issues, which I would like briefly to address. He mentioned accident and emergency departments, and they are already paid for the patients that they treat. Those services would not be subject to any willing provider as they need to be commissioned and planned to ensure that they are safe and clinically viable. The Bill allows local commissioners to designate services traditional protection, to ensure that the country is covered with the relevant number of services; for example, of A and E departments.

10 am

The hon. Gentleman also asked how one can avoid Monitor’s making decisions on narrow grounds. The answer is by requiring Monitor to have regard to exactly those broader issues that commissioners need to take into account. He also suggested that decisions should be made by a democratic body rather than Monitor. Monitor will not make decisions about which services are provided. It will ensure that the choices of patients and clinicians shape the development of services. Health and well-being boards give democratic oversight at a local level in a way that was not possible before.

The hon. Gentleman also asked what anti-competitive behaviour looks like. I hope that he will find these examples helpful. They include things such as colluding with a commissioner to keep out competitors; colluding to keep prices high when there is no national tariff; not offering patients the choice to which they are entitled; agreeing not to compete against each other; and sharing confidential cost information.

The hon. Member for Pontypridd raised a number of matters. I shall seek to answer him, although whether it is to his satisfaction remains to be seen. He spoke about competition law deciding what drugs are funded.

Owen Smith: That is not quite what I said.

Mr Burns: Yes, the hon. Gentleman said it during the course of his remarks; he must remember, because he spoke only a few minutes ago. The answer to his question is that it would be for commissioners, advised by clinicians, to decide which drug treatments are funded, not Monitor. I hope that my answer reassures him.

On the commissioning of clinical services, he asked whether procurement rules apply. We already have rules that govern the procurement of clinical services. It is the PCT procurement guide. It recognises that procuring clinical services is very different from procuring goods such as bed pans and so on, and the Bill recognises that by restricting Monitor’s role to clinical services.

I shall deal next with two matters raised by the hon. Member for Leicester West. She asked where the overall authority lies for deciding on the use of resources.

Liz Kendall: No, that is not what I asked.

Mr Burns: That was certainly the impression given by the hon. Lady. I shall answer anyway, as I am sure that she would have liked to have asked the question. Commissioners decide on the best use of resources and priorities for patient care. Monitor simply ensures that the system works fairly and in the interests of the patient. Patients decide who they want to treat them.

I hesitate to say so, but I think that the hon. Lady wanted to know where the overall authority lies for deciding how best to use resources. [Interruption.] Given that the hon. Member for Islington South and Finsbury is acting as a kind of Greek chorus, it seems that the hon. Member for Pontypridd did not ask that question. However, she will have the benefit of an answer so as to avoid confusion at a later stage. [Interruption.] God, that cackle!

The answer is simple. Commissioners secure the best quality services for patients in line with patient choices. The CQC ensures essential standards of safety and quality. Monitor ensures that services are efficient and fair. The Bill creates a much more coherent framework than the current confused mix of overlapping responsibilities.

In light of all that information, I hope that the Committee will agree that clause 54 should stand part of the Bill.

Liz Kendall: The question that I asked. [Interruption.] It is important to clarify it. Fair dues to me—I want to clarify the question that I asked. It is not who has
responsibility for quality or who has responsibility for resources. There are trade-offs and difficult decisions, and those issues need to come together. It is quite illuminating that in his reply, the Minister wished to separate the two and that, I am afraid, is the problem. That is the fundamental, difficult decision that needs to be taken in the NHS, both locally and nationally, whoever is in power. As for the difficult trade-off, it is not clear, under the Government’s proposals, whether the responsibility for the system as a whole lies with the NHS commissioning board nationally, GP commissioning consortia locally, the Care Quality Commission or Monitor. It is fair enough that the Minister does not take my word for it, but he should read the briefing from the King’s Fund. If he had been at the Westminster health forum, in which a number of eminent people, including David Bennett, spoke, he would have seen that such questions are being asked by the health policy world.

Mr Burns: There are trade-offs always existed within the NHS. There is no way of legislating them out of existence.

Liz Kendall: I am not seeking to do that.

Mr Burns: This Bill allows the trade-offs—and this is the critical thing—to be managed fairly and, more importantly, transparently to minimise any tensions and problems.

Liz Kendall: I do not believe that that is the case. This Bill could make it harder to balance these difficult trade-offs because of the responsibilities of the different bodies that are being set up. As I said, if the Minister will not listen to me—I understand that we sit on opposite sides of the Committee—I respectfully ask him to listen to the concerns of organisations such as the King’s Fund and the Nuffield Trust because this is a difficult issue.

Mr Barron: In a previous life, my hon. Friend was an adviser to a Secretary of State for Health. Has she any evidence of the Competition Commission being used to sort out problems within clinical services?

The Chair: Order. This is a debate on clause 54.

Liz Kendall: We are indeed discussing clause 54. I always bow to the decision of the Chair. My right hon. Friend raises the question that we will turn to when we discuss a later clause. The question is whether we should give a body the same powers as the OFT and the Competition Commission, which are not required to make those trade-offs. It is legitimate for my right hon. Friend to ask that.

In discussions that I have had with a number of organisations, it was said that responsibility is not included in the Bill. My hon. Friend the Member for Pontypridd and the hon. Member for Southport made the important point that Monitor does not have to live with the consequences—financial or otherwise—of its decisions. My hon. Friend raised that point in relation to research costs and the costs of expensive patients.

As for democratic accountability—I beg the Chair’s forgiveness for my over-long contribution—Monitor may be able to make decisions, which have serious implications for local people, but it is not democratically elected and it does not have to live with the consequences of those decisions. My—not philosophical—point was that, although I absolutely believe that we need to base decisions on fact and evidence, we also need to bring people with us, because ultimately it is the people’s national health service, and who is to say that some independent body, even if it has all the science behind it, has democratic legitimacy? That is a hard issue, which we have struggled with for many years. I, like hon. Members in all parts of the Committee, think that there has always been a democratic deficit in the NHS. We need to ensure that it is more accountable, but I am not sure that we should put powers in the hands of Monitor without that democratic legitimacy.

I listened very carefully to the hon. Member for Southport, who said that he is not wedded to primary care trusts, but wants greater accountability and legitimacy for decisions. Under the clause, Monitor will take significant decisions, but it will not have to live with the consequences of those decisions. There is no other body that can have that legitimacy at the moment. GP consortia do not have elected representatives. We cannot just say that it will be up to health and well-being boards, because they will not be making decisions on all the difficult trade-offs. We have debated whether they will have a say in reconfigurations of services, but they will not be responsible for those difficult trade-offs. Health and well-being boards cannot direct GP consortia to do anything. At the moment, there will not be democratic accountability in the system. The clause, like many others, does not resolve that issue, and therefore my hon. Friends and I are not able to support it.

Question put. That the clause stand part of the Bill.

Question accordingly agreed to.

Clause 54 ordered to stand part of the Bill.

YEAH

Mr Burns, Mr Simon
Burstow, Paul
Crabb, Stephen
de Bois, Nick
James, Margot

NOES

Abrahams, Debbie
Barron, Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Clause 55

CONFLICTS BETWEEN FUNCTIONS

Mr Burns: I beg to move amendment 376, in clause 55, page 64, line 32, after ‘period’ insert—
‘or under paragraph 17 of Schedule 7 to this Act (accounts of NHS foundation trusts).’

I hope that we will move quickly on this extremely straightforward amendment. As hon. Members will be aware, the Bill proposes that Monitor will have two main roles—its main role of economic regulator, and its functions in relation to NHS foundation trusts, under chapter 5 of part 2 of the National Health Service Act 2006. Monitor will need to have Chinese walls between its role of economic regulator and its functions on foundation trusts. The Government amendment will provide clarity that Monitor’s duty is to ensure that no conflicts arise in the exercise of its main functions, including those related to foundation trusts. It refers to Monitor’s specific functions on foundation trust accounts, and makes it clear that they will be covered by the provision on the conflict of interest. I hope that hon. Members will agree that the amendment is necessary and will support it.

Amendment 376 agreed to.

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

10.15 am

Liz Kendall: I have one or two points. Hon. Members will be aware that the Labour party does not support Monitor’s new role as an economic regulator, but as it moves towards that position, there is obviously a transitional period in which it remains responsible for part of the move of trusts into foundation trusts. As hon. Members will know, that will be extremely difficult and many organisations have queried whether it will be possible for all NHS trusts to become foundation trusts by 2016, as in the Government’s timetable. This is not just about hospitals; as primary care trusts separate out their provider role, community services will also become foundation trusts. There is a huge amount of work for Monitor to do.

As Monitor proceeds in trying to make all trusts ready for foundation trust status, the Bill seeks to ensure that there will be no conflicts of interest. A body cannot be the regulator of a provider as well as of the market, and I understand what the Government are trying to do. I would like clarity from the Minister about the resources that Monitor will have to ensure that every trust becomes an NHS foundation trust by that period. Does he believe that some NHS trusts will never be ready to become foundation trusts? Unfortunately, the list of the 20 hospitals that will not reach foundation trust status has already been published, and the chief executive of the NHS mentioned that to the Public Accounts Committee.

I am concerned about the timetable and the resources that Monitor has to secure all trusts that move towards foundation trust status. I understand what a “Chinese wall” means, but will the Minister explain what that would look like within Monitor?

Mr Burns: Clause 55 makes various provisions about how Monitor should handle potential conflicts of interest in relation to its functions. From listening to the hon. Lady, I get the impression that we agree that that is important and must happen. There is no conflict between us on that point.

It may be helpful if I say something about where such conflicts might arise. Clauses 52 and 54 create a number of general duties on Monitor. Its main duty, however, is to protect and promote the interests of people who use health care services by promoting competition where appropriate, and through regulation where necessary. Monitor must also promote the economic, efficient and effective provision of NHS health care services and, among other things, have regard to the need for commissioner to ensure fair access to services for those who need them.

In many cases, there will be a synergy between those duties, but at least in theory, there could be a scenario where the most economic, efficient and effective provision did not deliver fair access, for example because that access was limited to certain days and times, or locations. Hence, the clause creates a general duty on Monitor to make arrangements for resolving any conflicts of interest that it considers there are between any of its general duties. The provision makes it clear that, in cases where the general duties conflicted, there would be no external authority to which Monitor could or should turn for resolution. Subsection (2) is about how Monitor would achieve two of its functions: its main role of economic regulator and any of its continuing functions in relation to NHS foundation trusts under chapter 5, part 2 of the National Health Service Act 2006.

Once Monitor has taken on the role of the economic regulator, its main role in relation to foundation trusts will be that of registrar. That will include, in the short term only, determining what foundation trusts must include in their annual reports. Monitor will also have functions in relation to foundation trusts arising from its time-limited transitional powers over all new and some existing foundation trusts; and its ability to trigger the transitional failure regime in relation to foundation trusts. In the short term, Monitor will need Chinese walls in relation to its role as economic regulator and its functions in relation to foundation trusts.

Similarly, subsection (3) provides that, when carrying out its competition, licensing and pricing functions, Monitor must ignore those of its functions that would enable it to intervene in NHS foundation trusts for a time-limited period during the transitional period, while the new governance arrangements in new, and some existing, foundation trusts, become fully effective. That includes ignoring the power that it has to impose additional licence conditions in cases where it considers there is a significant risk of a newly designated foundation trust failing to meet its principal purpose. Under the subsection, Monitor could not take account of the fact that it was intervening in a foundation trust when considering whether there had been a breach of competition law involving the same trust.

Subsections (4), (5), (6) and (7) cover conflicts between Monitor’s general duties that are, in ways specified in the clauses, significant. The provision also applies to any other conflicts of interest that Monitor considers
are of unusual importance. In all those cases, Monitor must publish a statement setting out the nature of the conflict, the manner in which Monitor has decided to resolve it and its reasons for the decision. That is an important provision in relation to transparency and public accountability.

Taken as a whole, the clause makes provision for real-life conflicts of interest that Monitor might encounter in exercising its functions, and ensures that Monitor is clear how it should deal with them. It also ensures there would be transparency in cases where there might be significant public interest.

The hon. Lady also asked: what are Chinese walls? Those would be a complete separation of functions, roles, people and information below the chairman in Monitor. Monitor could, for example, set up a separate committee to deal with its specific foundation trust functions to provide that protection. The hon. Lady also tried to tempt me on the foundation trust pipeline. That will not be Monitor’s job. We are setting up a separate time-limited authority to manage the FT pipeline. For those reasons, I urge that clause 55 stand part of the Bill.

Liz Kendall: I thank the Minister for his reply. I am not necessarily convinced that a committee of Monitor, beneath the chair, with separate information streams—if that were possible in a big organisation—is a genuine Chinese wall. I am keen to see further information on that. Anyone who has run a big organisation knows that just having a committee does not mean that it is a separate function, or necessarily a safeguard. That is a serious issue, raised by the Foundation Trust Network and others, about how that conflict of interest can be safeguarded. I am not sure that the Minister’s response is sufficient, but I would be glad to hear more.

10.25 am
The Chairman adjourned the Committee without Question put (Standing Order No.88).

Adjourned till this day at One o’clock.