Contents

Clauses 55 to 59, 39 and 45 agreed to, some with amendments.
Schedules 4, 5 and 6 agreed to, with amendments.
Clauses 46 and 60 to 68 agreed to, some with amendments.
Adjourned till Tuesday 22 March at half-past Ten 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.

No proofs can be supplied. Corrigenda slips may be published with Bound Volume editions. Corrigenda that Members suggest should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Monday 21 March 2011

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

(Afternoon)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

Clause 55

CONFLICTS BETWEEN FUNCTIONS

1 pm

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

The Chair: To give Liz Kendall time to get into the room, I call Jeremy Lefroy. I will then come back to you, Liz.

Jeremy Lefroy (Stafford) (Con): Thank you, Mr Hancock. I should like to make a few comments on clause 55 and in particular on the continuing function of Monitor in the approval of foundation trusts. I will refer to evidence given at the Francis inquiry on Monday this week during the questioning of Mr Gill, who was working for or on secondment to the Department of Health and the strategic health authority for some of the period with which the Mid Staffordshire NHS Foundation Trust independent inquiry is concerned. I am referring to page 49 of the evidence. The QC put it to Mr Gill that

“there appears to have been...a drive to get SHAs to put trusts forward for foundation trust status. Here, Warren Brown...is saying ‘SHAs may be putting trusts in waves that have no business being there’.”

—that is, pushing them forward for FT status inappropriately. Mr Gill answered:

“I think a number of SHAs gave the FT pipeline, as it was called, a different priority. So some really embraced it, wanted to work with the Department and get their organisations through to FT status. Other SHAs, perhaps, saw that as a dilution or diminution in power”.

Further on in the evidence is this statement:

“I think...the Department of Health wanted a nice, clean kind of throughput of organisations through to Monitor to meet the quarterly waves.”

Those were waves of foundation trusts going forward for approval—[Interruption.]

The Chair: Sorry, I thought that the Minister was trying to catch your eye.

Jeremy Lefroy: I think that he was just paying attention, Mr Hancock.

The Chair: Others have said that would make a change, but I do not believe that is true.

Jeremy Lefroy: I am most grateful that the Minister always pays careful attention to what all hon. Members on both sides of the Committee say.

The evidence also refers to “the ministerial or political view that all trusts would be ready to apply or” have “the opportunity to apply” for foundation trust status “by December 2008”.

There is much more in the evidence, and I urge members of the Committee to look at it on the inquiry website. The point that I want to make and the question that I want to raise with the Minister is this. Clearly, how Monitor views the ongoing process of approval for foundation trust status is extremely important. I want an assurance from the Minister that that process will be rigorous and thorough and that those involved will consider carefully the mistakes made in the past and learn the lessons.

The Minister of State, Department of Health (Mr Simon Burns): My hon. Friend makes an important point. I am happy to give him that assurance. I would also like to tell him, because I think that it will encourage him, that there is no question of NHS trusts being allowed to sacrifice quality while developing their application to become an FT. To achieve FT status, a trust must be able to demonstrate that it is delivering high-quality care and is well managed and financially strong. The FT process has improved considerably during the last two years to address some of the very failings that my hon. Friend highlighted with regard to the Mid Staffordshire NHS Foundation Trust. That trust achieved FT status despite very poor standards of care. The changes to the assessment process have ensured that quality is the key focus for trusts working towards FT status. I hope that that explanation provides some of the assurances that my hon. Friend seeks.

Jeremy Lefroy: I thank the Minister for that explanation. I am glad because I would not want any trust to have to go through the problems that we have seen in the Mid Staffordshire trust.

My final point is that I am absolutely convinced that there should be no timetable for approval for foundation trust status, although there might be an indicative timetable saying, “We would like to get to this point by this date.” I am glad to hear the Minister’s reassurance on that. It is critical that no timetable should take precedence over the concern for quality and for rigour in the approval process.

The Chair: I now call Liz Kendall.

Liz Kendall (Leicester West) (Lab): Thank you, Mr Hancock, for giving me some time to gather myself. My comments follow directly on from the, as always, wise words of the hon. Member for Stafford. I absolutely want to learn from the problems experienced at the Mid Staffordshire trust, as I am sure my hon. Friends do, so I am grateful to the hon. Gentleman for raising the issue.

The Minister responded to my opening comments in the clause stand part debate, but he did not respond to some of my specific questions about the work load that Monitor will have in getting all hospitals to foundation trust status or about the difficulties and the time scale involved, and we need to be clear about those issues.
In the past six years, 134 trusts have got foundation trust status. Monitor estimates that about another 120 NHS trusts will need to be authorised to get every trust to foundation trust status. Let us be clear, however, that Monitor is also looking at about 30 major transactions that foundation trusts are involved in, and it will look at any future transactions between trusts that are currently NHS trusts, but which will take on foundation trust status. Monitor has said that that means it will probably have to make 150 or so assessments of one sort or another over the next three years, compared with the 134 that it has looked at over the past six years. At the recent Westminster health forum, David Bennett said: “That is going to be a very big step up in workload, although one that will come to, at least in principle, a rather abrupt end in April 2014 once the last Trusts are authorised.”

Does the Minister expect all the trusts to be authorised by then?

Interestingly, David Bennett then said:

“Having said that, the real challenge is not for us, it’s for the Department of Health, because it is for the Department of Health to get all of these NHS Trusts to a position where they can become Foundation Trusts, and that, undoubtedly in some cases at least, will be very challenging.”

How will the Government get twice the number of NHS trusts ready for foundation trust status, when those trusts involved are likely to be the ones with the biggest challenges, because they are not the ones that moved quickly to foundation trust status?

How will Monitor make sure—I asked this earlier—that the governors in every trust across the country have the skills and expertise necessary? As I have said, making sure that every hospital in the land has governors with sufficient experience and of sufficient quality to manage budgets of millions of pounds is a very real challenge. Monitor is supposed to help to train governors to do that, but it is a huge challenge. What steps is the Department taking to deal with that? The Minister said that a separate authority is being set up to do these things.

Mr Burns: In an effort to help the hon. Lady, let me tell her that we recognise that some NHS trusts have significant problems or face significant challenges. That is why we are setting up a temporary special health authority, on a time-limited basis, that will provide dedicated support, including senior clinical expertise, to help those trusts to move forward and to deal with some of the situations that they face.

Liz Kendall: The Minister says that he is setting up a “time-limited” special authority. It would be very useful to learn from him whether any plans, outlines or proposals for that special authority have been set out. I am sure that many MPs, not just those in this Committee, would like to know what this authority is. Who will it be run by? What is its budget? How can MPs relate to this special authority if they have a trust in their own area that is struggling to gain foundation trust status?

Mr Burns: As the hon. Lady will understand from her knowledge of working in a previous Administration, it will be a special health authority.

Liz Kendall: That could mean anything. I want the Minister to give some details. Have any details have been set out or published about the special authority? Who will be on it and how will it be run?

Mr Burns: If the hon. Lady wants a specific answer to that question, it is quite simple: we set out details in our response to the consultations on the White Paper.

The Chair: Order. We have to direct our minds to clause 55 and we must consider where we are going, given the present tone of the debate. I am not altogether sure that I understand where you are taking us on this one, Ms Kendall.

Liz Kendall: Mr Hancock, as is often the case, you remind us that we must remain on the clause under debate. The clause sets out how Monitor will attempt to resolve conflicts of interest between its different roles: its current role of regulating foundation trusts, which it is going to lose, and its new role as an economic regulator; and what it will do in the transition period. I am focusing my comments on the transition period, which is one of the subjects of the clause. Having said that, Mr Hancock, I will of course abide by your ruling. If you prefer that I return to this subject when we debate the clauses on foundation trust clauses, I will be more than happy to do so.

The Chair: I think that there is general agreement that that would be a more appropriate spot for that discussion.

Liz Kendall: I will come back with more questions when we debate foundation trusts.

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

Clause 56
DUTY TO REVIEW REGULATORY BURDENS

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

Grahame M. Morris (Easington) (Lab): The clause requires Monitor to review regulatory burdens as part of its functions as the regulatory body for the new health market. It must ensure that it does not either impose or maintain unnecessary burdens. According to the Bill, not only must Monitor impose only regulation that it deems necessary and proportionate but it must determine whether its own regulation is necessary and proportionate. I suggest that there is a tension between those two roles.

David Bennett, the chief executive of Monitor who has often been quoted in this Committee, said in his recent interview with The Times that Monitor’s aim will be to create a genuine market for fair competition between providers. However, that would require a fair plying field between competing providers, and as things stand, there cannot be a fair playing field, due to the differential costs that apply to different types of organisation. The Opposition are genuinely concerned that Monitor will decide to act against those differential costs, which it will justifiably view as regulatory burdens. The Bill certainly gives it the powers to do so, and David Bennett’s comments fit in with that scenario.

1.15 pm
I have previously referred to the Government’s impact assessment of the Bill. On closer examination, it is most revealing in relation to what clause 56 could mean and
what action Monitor may be obliged to take as a result of it. Paragraph B108 states:

“The regulator will also be tasked with publishing advice...on barriers to competition/ fair playing field...and implement recommended solutions...Once the net distortion facing different provider types is better understood, the tariff methodology could be developed in such a way as to move towards a fairer playing field”—

this is really important—

“different prices for different providers.”

That is a key point, to which Monitor’s chief executive, David Bennett, referred.

The Minister of State, the hon. Member for Sutton and Cheam, and I have had a number of exchanges on the matter. On 4 February, in a reply to a written question, the Minister said:

“The impact assessment for the Health and Social Care Bill...includes a partial assessment of factors affecting the costs incurred by national health service bodies and private providers, respectively, in delivering health services for NHS patients. The key conclusion is that some of these factors appear to increase costs for NHS bodies relative to private providers, whilst other factors appear to increase costs for private providers relative to NHS bodies. However, based on the information held centrally, it has not been possible to determine, on balance, whether NHS bodies or private providers of NHS services are systematically advantaged or disadvantaged relative to the other.”—[Official Report, 4 February 2011; Vol. 522, c. 1007W]

I confess that I have struggled to reconcile that ministerial answer with the Government’s impact assessment. Paragraph B55 states unequivocally:

“The majority of the quantifiable distortions work in favour of NHS organisations”.

In layman’s terms, NHS providers are able to provide services at a cheaper cost base than private providers. The impact assessment also has an intriguing section on the cost of capital. In it, the Government admit that public investment is far more efficient than private borrowing. I do not want to deviate from the clause, but there is a credibility gap between the Government’s rhetoric on the private finance initiative and what is actually happening on the ground. There are issues around deeds of safeguard that need to be tackled elsewhere. Alarmingly, the point about the cost of capital is viewed as a problem rather than an argument for the publicly funded investment that we all want.

The impact assessment goes on to outline how to remove the distortion when creating private markets. Whether the Minister or the impact assessment is correct is irrelevant because we have to deal with the provisions in the Bill. It will be the duty of Monitor, not the Minister, to take action and resolve these problems. The impact assessment uses KPMG research into fair playing fields, which calculated additional costs for private providers at 14%. By and large, according to KPMG, NHS providers are 14% cheaper.

In the view of Opposition Members and some informed commentators, the spectre of European competition regulations and rules on state aid are quite important. Monitor will be under pressure to give either tax breaks or subsidies to private providers, or to put additional costs on to NHS providers. Unless the Minister is willing to reduce the scope of powers given to Monitor by this Bill, it will not be able to offer any guarantees on decisions that will be out of its hands.

The King’s Fund has described Monitor’s duty as “strikingly similar to the original duty on Ofgem...in that the duty to promote competition is closely linked to the duty to protect and promote the interests of service users.”

My hon. Friend the Member for Leicester West has set out in a most comprehensive manner the key differences between utilities and health services. The public would find such a comparison objectionable.

Monitor’s power within the health service will dominate the provision of future services. The Bill suggests that it will take a prime position over the bodies responsible for quality, notably the Care Quality Commission. The clause gives Monitor unnecessary control over the market by giving it the power to fix costs and act against the naturally cheaper and better option, the NHS provider. I would argue that if the Government are sincere about rejecting price competition, Government Members should take this opportunity to vote against clause 56.

Mr Burns: I hope the Committee will be satisfied if I deal with this clause relatively briefly, rather than having a long drawn out debate, because we have a considerable amount of work to get through this afternoon.

Clause 56, as we know from clause 52, ensures that Monitor’s main duties are to protect and promote the interests of people who use health care services by promoting competition where appropriate and by regulating where necessary to enhance quality. Clause 56, therefore, requires Monitor to keep those regulatory practices under review so it does not increase or retain unnecessary regulatory burdens, and, through that, it will ensure best regulatory practice.

Over time, as the health care markets change and competition becomes more embedded and efficient, Monitor will adapt the way it regulates those services, particularly where regulatory activity is no longer necessary. It will also be possible for it to reduce certain regulatory activities for certain types of providers, which would ensure that regulation is applied proportionately and only where necessary. That would ensure sufficient regulation while keeping burdens and costs to a reasonable minimum. Monitor, under this clause, will publish statements reporting its actions for every 12-month period and its plans for future regulatory changes.

Grahame M. Morris: Will the Minister confirm that Monitor could invoke those powers when a private provider complains under competition law that a GP commissioner is favouring the incumbent provider, such as an NHS foundation trust?

Mr Burns: The answer is, in theory, yes.

May I pick up another point raised by the hon. Gentleman, which was about Monitor giving higher prices to private providers? As the hon. Gentleman so clearly showed, we have tabled Government amendments to make our position on pricing completely clear. We will reach the relevant clause, which addresses pricing, in due course. I will tread very carefully so as not to go down a cul-de-sac and stray out of order, Mr Hancock. Amendment 192 to clause 104 will ensure that Monitor cannot vary prices according to whether a provider is public or private. We will debate that later, and I am sure the hon. Gentleman will have a considerable amount to say about it, although I hope he studies the amendment carefully so he fully understands it.
The Chair: That the clause stand part of the Bill.

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

The Committee divided: Ayes 13, Noes 10.

Question accordingly agreed to.

Clause 56 ordered to stand part of the Bill.

Clause 57

DUTY TO CARRY OUT IMPACT ASSESSMENTS

Liz Kendall: I beg to move amendment 482, in clause 57, page 66, line 21, leave out subsection (2).

The Chair: With this it will be convenient to discuss the following: Government amendments 377 and 378.

Amendment 489, in clause 62, page 68, line 40, leave out subsection (2).

Liz Kendall: The clause deals with Monitor’s duty to carry out impact assessments. As we know, there are various duties on Government to produce different impact assessments on various Departments, and the clause sets out Monitor’s duties in that regard.

Amendment 482 would delete subsection (2), which states that any of Monitor’s duties to carry out impact assessments do not apply to those duties for which clauses 60 and 61 provide. Those clauses give Monitor similar powers to those of the Office of Fair Trading under the Competition Act 1998 and the Enterprise Act 2002. In other words, no impact assessment is required for anything that Monitor does in exercising its competition duties. It seems astonishing that Monitor does not have to produce an impact assessment when carrying out the same functions that the OFT has under the 1998 Act, it needs to use reasoning that is in line with the law. A decision that is reached based on an understanding of the health care market. The amendment would, therefore, be extremely inappropriate.

Liz Kendall: will, Mr Hancock, because amendment 489, I am reminded by my notes, relates to clause 62. It would delete subsection (2) of that clause, which states that Monitor’s general duties, as set out in clause 52, and matters to which it must have regard, which discussed under clause 54, “do not apply in relation to anything done by Monitor in the carrying out of its functions by virtue of” clauses 60 and 61. In other words, when Monitor is carrying out the same functions that the OFT has under the 1998 and 2002 Acts, it does not have to pay regard to its general duties or to other matters to which it must have regard. The kindest way of looking at this is that it is badly drafted and completely unclear. I apologise to any civil servants sitting here who might have been involved. What is the point of setting out duties and matters to which Monitor must pay regard, then saying that when it is exercising pretty much its main functions it does not have to bother with them? What is the point of having a duty to conduct impact assessments when they do not have to be done? That is entirely wrong.

1.30 pm

Mr Burns: If I may, Mr Hancock, I will address amendments 482 and 489 before moving on to amendments 377 and 378.

Clause 62 enables Monitor to act in a manner similar to the OFT for its concurrent functions as competition authority, which are granted under the Competition Act 1998 and the Enterprise Act 2002. There is significant overlap between the matters to which the OFT must have regard in protecting consumer interests, and Monitor’s duties in protecting patients’ interests.

In deciding whether to take a case under the 1998 Act, Monitor could consider how doing so fitted into the performance of its overall duties. That is to say that it must make the best use of its resources and it is legally permitted to apply administrative priorities when deciding whether to take cases; its administrative priorities would reflect its duties. We must avoid inconsistency in the legal framework, however, for concurrent competition authorities such as Monitor and the OFT. To do otherwise would undermine the UK’s competition regime and put Monitor at risk of legal challenge. Amendment 489 would create such an inconsistency.

Monitor must be subject to the established duties that apply to the OFT to allow it to perform its competition authority function effectively and in the best interests of patients and taxpayers. It is worth remembering that the OFT could currently take action under the 1998 Act against undertakings providing health care services. In so doing, it would have regard to the usual matters that a competition authority could take into account, such as the market share of the undertakings concerned and the impact on consumers.

The drafting in the Bill, therefore, maintains the legal powers as they already are but with the added benefit of establishing a sector-specific regulator for health and concurrent powers. The advantage of a sector-specific regulator is the potential for enhanced knowledge and understanding of the health care market. The amendment would, therefore, be extremely inappropriate.

I turn to impact assessments. When Monitor applies the 1998 Act, it needs to use reasoning that is in line with the law. A decision that is reached based on an
impact assessment would be subject to legal challenge. An investigation under the 1998 Act would have an impact on the persons who are under investigation, and it would not be appropriate for such an impact to determine whether it was appropriate to pursue the case. I fully expect Monitor to consider the potential impact on patients before deciding whether to investigate a case under the 1998 Act. I think that amendment 482 might make us subject to legal challenge, and for the reasons that I have given I will resist amendments 482 and 489.

It is worth bearing in mind, however, that the 1998 Act involves consideration of factors other than the effects on competition. For example, agreements are permitted that contribute to the improvement of the production or distribution of goods or the promotion of technical or economic progress, while allowing consumers a fair share of the resulting benefit, provided that they do not impose unnecessary restrictions and they do not allow undertakings to eliminate competition entirely. We will undertake an impact assessment of the regulations that are permitted under clause 63 on GP consortia and the NHS commissioning board. That will ensure that all the impacts resulting from the requirements that are placed on commissioners are taken into consideration.

Finally, I would like my hon. Friends also to consider Government amendments 377 and 378, which clarify clause 57 and remove unnecessary duplication. Clause 57(2)(a) refers to clauses 60 and 61, and we propose to remove that paragraph. It is not necessary, because paragraph (c) refers to the entirety of chapter 2, which includes clauses 60 and 61. The addition of “by virtue of” clarifies that the duty to carry out impact assessments does not apply in relation to any of Monitor’s functions under chapter 2, irrespective of whether they are specified in primary legislation or, for example, in regulations made under that chapter.

**Liz Kendall:** I do not think that the Minister has adequately explained what Government amendment 377 does. Clause 57(1)(a) says that Monitor has to carry out an impact assessment when it proposes to do something it considers would “be likely to have a significant impact on persons who provide health care services for the purposes of the NHS”.

So Government amendment 377 says that Monitor does not have to do an impact assessment if it affects staff. I respectfully request that the Minister be clearer about the amendments that he tables, because this amendment says that when Monitor exercises its functions under competition law, it does not have to look at the impact on staff. That is how I read it, and I would appreciate more clarity on that. It is wrong; any impact assessment should look at the impact not only on the users of services, but on the staff, who the Government often say they very much want to involve in decisions.

To my mind, the Government either want Monitor to pay regard to patient safety, improving quality, fair access, better use of resources and promoting investment, research, and high standards in education and training, or they do not. If they do, they should not say in their legislation that these are not issues that Monitor must pay regard to when exercising its functions under the 1998 and 2002 Acts.

The Government either want to ensure that there are impact assessments that set out the impact of Monitor’s decisions on people who provide and use services, and the general public, or they do not—in which case, the Government should not say that Monitor does not have to do an impact assessment when exercising its competition functions. The Minister has not explained that. As I said earlier, the nicest interpretation is that it is a legal mess—clauses are being added here and there—because the different parts of legislation do not fit. Alternatively, the real reason for the subsections in clauses 57 and 62 is that the Government do not intend Monitor to deliver these laudable goals, but instead want it to promote competition in all parts of the NHS with no regard to the impact on the people or the providers of those services.

**Question put.** That the amendment be made.

The Committee divided: Ayes 10, Noes 12.

**Division No. 49**

**AYES**

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

Smith, Owen
Thomberney, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

**NOES**

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Soubry, Anna
Sturdy, Julian

**Question accordingly negatived.**

Amendment proposed: 377, in clause 57, page 66, line 22, leave out paragraph (a).—(Mr Simon Burns.)

**Question put.** That the amendment be made.

The Committee divided: Ayes 13, Noes 10.

**Division No. 50**

**AYES**

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

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

**NOES**

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

Smith, Owen
Thomberney, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

**Question accordingly agreed to.**

Amendment 377 agreed to.

Amendment made: 378, in clause 57, page 66, line 25, after ‘under’ insert ‘or by virtue of’.—(Mr Simon Burns.)

**Question proposed.** That the clause, as amended, stand part of the Bill.
John Pugh (Southport) (LD): I want to make a few remarks to clear things up—in my own mind, if no one else's. Some concerns have been raised that I have not previously had a chance to ask the Minister about.

It strikes me that the fundamental thrust of the legislation is to create a regulator who will stamp out anti-competitive practice and bring the benefits that people perceive competition to have. The Minister has explained that we are not talking about crude competition, that a series of other issues must be taken into account—we might call them mitigating factors—and that impact assessments are to be made. We have just argued about what they mean in effect, and we seem to be creating an entity that is slightly more than a simple regulator—almost a strategic body capable of making decisions that have major consequences. It will be an unaccountable body and, as I said this morning, it will not have to deal directly with the consequences of its decisions.

I shall give an analogy that helps me, although it might not help anyone else. We are perfectly happy for referees to decide matters such as the offside rule and to implement a set of bloodless rules, but if they must make judgments about how the game is going, and whether it is being played well or badly enough, we are less happy, and think, “What right does he have to decide such matters?” If we have a hard and fast set of rules, and we know clearly what they are and how they should be applied, we are comfortable. In other situations, we are less than happy.

The burden of my remarks is not only that Monitor could create a problem that it does not have to manage, but how it will meld—the hon. Member for Halton could create a problem that it does not have to manage, and, as I said this morning, it will not have to deal directly with the consequences of its decisions.

I gave an example this morning of an issue in my constituency. I am still not clear about it. I could ask Assura Medical to provide a Southport walk-in centre for children, and accept the risk because there are photographs of him campaigning for such an activity. It does not exist.

So on—it must be observed that there is no regulator for the system we have for the procurement of other competitive regulation for clinical services, analogous to the system we have for the procurement of other kinds of hospital services—the beds, the beds and so on—it must be observed that there is no regulator for such an activity. It does not exist.

Grahame M. Morris: That is an excellent point, well made, and I want to amplify it, particularly in relation to the hon. Gentleman’s example of pathology services and the risk of charges of anti-competitive behaviour. It strikes me, as someone who worked in the pathology service, that this is being followed in the Merseyside area to get the budget under control and make the appreciable savings that are necessary.

I see all those problems generated by the creation of Monitor. I cannot help thinking that we are creating a bureaucratic monster, with a whole series of different ancillary roles that are not necessarily mutually consistent. It will cost a lot of money, and I do not understand why we are doing it. If the thrust is to have a system of competitive regulation for clinical services, analogous to the system we have for the procurement of other kinds of hospital services—the beds, the beds and so on—it must be observed that there is no regulator for such an activity. It does not exist.

John Pugh: It is not an academic point. In the north-west and Merseyside, we are trying to maintain access and facilities as best we can—and this is not something that the Government have done, because the £20 billion is a consequence of the Budget in which the then Chancellor, the right hon. Member for Edinburgh South West (Mr Darling), said we would have to find that saving.
The way to maintain access and facilities is to ensure that the hospitals are colluding as to the activities they are engaging in. That is the least painful way of doing it. The other way is to beat one another to death and have facilities go down in different areas and to have access diminish. I do not see how we can run with the remit of Monitor and simultaneously make a quick saving. I would be grateful if the Minister explained how this would happen. I am making a serious point; I am not trying to get one over on the Government or whatever. I am making the point because I am worried. I am really worried.

My final point is that we are creating something that we have decided is going to grow in cost. It is going to be a big bureaucracy. We are giving it a lot of roles and a lot of different considerations. Not all of them seem to dovetail together, which is going to be more difficult and more legally complex. Why are we doing it? Local authorities and well-being boards and local authorities joining up. The way to maintain access and facilities is to ensure that service to the local consortium?

Jeremy Lefroy: I shall follow on from what my hon. Friend the Member for Southport has said and raise one further question with the Minister. It is a genuine question about how this legislation would impact on a specific case. When I say “a specific case”, I do not mean specific to my constituency, but a specific general case across the country.

Many general practices have community pharmacies within them. Many of those practices reinvest the profits from the pharmacies into other services that they provide to the community—they do not take them out for partners; they put them back in. I can think of one particular practice in my constituency that does precisely that.

The question I raise with the Minister is about whether such a practice would be considered, or be at risk of being considered, anti-competitive. For instance, would another provider of, for instance, the home visits to cancer patients, which the practice provides out of the profits from its pharmacy, be considered anti-competitive by another provider that potentially wanted to offer that service to the local consortium?

Liz Kendall: I am inspired by the hon. Member for Southport and I have been thinking about this for some time. It seems as if the Bill is developing two parallel universes in the NHS. One is from the NHS commissioning board driving GP commissioning consortia with—question mark—a degree of accountability, with some health and well-being boards and local authorities joining up. There is that world. Then there is the world of the economic regulator and competition law driving changes in the system. My question is about how on earth the two relate to one another.

I think that a battle is developing between the world run by David Nicholson and the NHS commissioning board and the world run by David Bennett at Monitor.
The hon. Member for Southport asked a number of questions, and I shall deal with them briefly. He spoke about competition law preventing collaboration in general. I believe that competition law would not preclude collaboration—for example, shared pathology services would improve services and be in the interests of patients and taxpayers.

The hon. Gentleman also spoke about Monitor and QIPP. I believe that Monitor will help drive greater efficiency and productivity for the benefit of patients and taxpayers. There is growing evidence that well designed competition can improve efficiency as well as drive up clinical quality. Health and well-being boards cannot hold Monitor to account for decisions on anti-competitive behaviour. Although Monitor does not sit on a health and well-being board, commissioners do, and the board can challenge the commissioners directly about their commissioning decisions.

I hope that I have clarified matters for the hon. Gentleman. For that reason, and given my earlier comments, I urge that clause 57 stand part of the Bill.

2 pm

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

The Committee divided: Ayes 13, Noes 10.

Division No. 51

**AYES**

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

**NOES**

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

Question accordingly agreed to.

Clause 57, as amended, ordered to stand part of the Bill.

Clause 58 ordered to stand part of the Bill.

Clause 59

**FAILURE TO PERFORM FUNCTIONS**

Mr Burns: I beg to move amendment 495, in clause 59, page 67, line 24, at end insert ‘and that the failure is significant’.

The Chair: With this it will be convenient to discuss Government amendments 496 and 497.

Mr Burns: The clause provides powers for the Secretary of State to direct Monitor when he considers that it is failing or has failed to perform a function. The Secretary of State may direct it to carry out the functions within a specified time frame or, when Monitor fails to comply with such a direction, to carry out the functions himself or arrange for other persons to do so. The clause does not set out how that power should be exercised, and I am recommending these amendments so that that is made clear.

Monitor will be the economic regulator of health care services. We do not intend to compromise Monitor’s independence or undermine the benefits of economic regulation by allowing for political interference in its decision making. However, we need to strike a balance. Monitor will continue to be a non-departmental body, and, as such, we need to ensure its political accountability. The Secretary of State will be able to direct Monitor only in respect of significant failings in the performance of its functions, and will not be able to intervene in individual cases. Where the Secretary of State does intervene, he or she will be required to publish a statement on his or her reasons for doing so.

The amendments are needed to make the accountabilities clear and to ensure that Monitor is, as far as possible, independent and protected from political interference. At the same time, they will ensure that steps can be taken should there be significant failings by Monitor in the performance of its functions as an economic regulator. The amendments will also bring Monitor into line with the Government’s proposed overarching principles for economic regulation, which the Department for Business, Innovation and Skills published in January.

Question put, That the amendment be made.

The Committee divided: Ayes 13, Noes 10.

Division No. 52

**AYES**

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

**NOES**

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

Question accordingly agreed to.

Amendment 493 agreed to.

Amendment proposed: 496, in clause 59, page 67, line 26, at end insert—

‘( ) But the Secretary of State may not give a direction under subsection (2) in relation to the performance of functions in a particular case.’—[Mr Simon Burns.]

Question put, That the amendment be made.

The Committee divided: Ayes 13, Noes 10.

Division No. 53

**AYES**

Brine, Mr Steve  
Burns, rh Mr Simon  
Burstow, Paul

**NOES**

Byles, Dan  
Crabb, Stephen  
de Bois, Nick

Question accordingly agreed to.
Question accordingly agreed to.

Amendment 496 agreed to.

(Amendment proposed: 497, in clause 59, page 67, line 31, at end insert—

'( ) Where the Secretary of State exercises a power under subsection (2) or (3), the Secretary of State must publish the reasons for doing so.'—(Mr Simon Burns.)

Amendment 496 agreed to.

The Committee divided: Ayes 13, Noes 10.

Division No. 54]

AYES

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

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Smith, Owen
Thornberry, Emily
Turner, Karl

NOES

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

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

Question accordingly agreed to.

Amendment 497 agreed to.

Question put, That the amendment be made.

The Committee divided: Ayes 13, Noes 10.

Division No. 55]

AYES

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

Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Smith, Owen
Thornberry, Emily
Turner, Karl

NOES

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

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

Question accordingly agreed to.

Clause 59, as amended, ordered to stand part of the Bill.
In summary, the amendments are minor, consequential and correcting. For that reason, I hope that the Committee will support them and that the clause, once amended, will stand part of the Bill.

Amendment 222 agreed to.

Amendments made: 223, in clause 39, page 55, line 11, leave out ‘(1A)(b)’ and insert ‘(1A)(d)’.

Amendment 224, in clause 39, page 55, line 15, leave out ‘(1A)(b)’ and insert ‘(1A)(d)’—[Paul Burstow.]

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

Derek Twigg (Halton) (Lab): This is quite an interesting clause, which we want to explore. The Minister has made some consequential amendments, but he understands that we are opposed in principle to the changes to the Secretary of State’s powers, and I will come back to that. The explanatory notes go on to say that this provision is extending the Secretary of State’s power to give directions to any body or person exercising functions under the Act, other than the NHS foundation trusts, but foundation trusts are important to this clause.

Paul Burstow: The hon. Gentleman says that he is “opposed in principle”. I want to be clear. The motion that he tabled and had his name added to yesterday listed a whole host of the principles on which the Bill is based. Is he sure that he is against the principle?

Derek Twigg: Perhaps the Minister has misunderstood me. I said that we are opposed to the proposals in the Bill to change the Secretary of State’s powers. We can go back to the duties to promote health services and so on, and I will come to that in my speech.

We read the clause with great interest following the first debate that we had about the changes to the role of the Secretary of State on the first day of scrutiny. The Minister may recall that we particularly opposed the clause, which we want to explore. The Minister has made some strong points, but the Minister did not take those on board, and we were disappointed with that.

2.15 pm

The clause removes the current duty on the Secretary of State in section 1(2) of the National Health Service Act 2006 to “provide or secure the provision of services” for the purpose of the health service. So the Secretary of State is currently directly responsible for providing or securing the provision of health services, and I hope the Minister understands that that is my point.

Section 253 of the 2006 Act confers on the Secretary of State the power to give directions to any body or person exercising functions under the Act, other than the NHS foundation trusts, when he considers that “by reason of an emergency it is necessary to do so in order to ensure that a service failing to be provided under or by virtue of this Act is provided.”

The explanatory notes say:

“This clause amends the section so as to extend the Secretary of State’s powers and make them consistent with the new framework for the health service provided for by the Bill.”

The opening phrase says that it extends the Secretary of State’s powers, and I will come back to that. The explanatory notes go on to say that “unlike the existing position under section 8 of the NHS Act, the Secretary of State will not have a general power to give directions to NHS bodies about how they exercise their functions.

Subsection (2) amends section 253 so that the Secretary of State can give a direction under the section where he considers it is appropriate, not just necessary, to do so by reason of an emergency. In addition, the effect of the amendment is that the power is not limited to giving directions to ensure that a service is provided. Subsection (3) provides that the Secretary of State’s power to direct applies to all NHS bodies except Local Health Boards (which are Welsh NHS bodies).

Interestingly, and this is an important change, the provision includes NHS foundation trusts, according to the explanatory notes.

I remind the Minister that the White Paper says: “The Government’s intention is to free foundation trusts from constraints they are under”.

I will not stray into next week’s debate on foundation trusts, but foundation trusts are important to this clause.

Clauses 158 to 163, which address the failure of foundation trusts and the transfer of powers to Monitor, are relevant. Clause 114, which details the health special administration orders, as outlined by explanatory note 745, is also relevant. As we read it—this is important—Monitor’s role in relation to foundation trusts is changing because, of course, there is no early intervention, as there is under our current procedure. I will come back to that in a minute.

Paul Burstow: I want to make sure I understand the flow of the argument being developed by the hon. Gentleman. This clause deals with the Secretary of State’s emergency powers. Is the hon. Gentleman suggesting that the Secretary of State should not have an emergency power to direct foundation trusts?

Derek Twigg: I am making a point about the change in the Secretary of State’s powers compared with his powers under the previous regime. When the Minister answers my questions, perhaps he might be able to explore that a bit further. Under what circumstances might the Secretary of State’s powers be used in relation to the foundation trusts?

As the hon. Member for Stafford is here, the failure at Mid Staffordshire might be a useful example. Will the Minister explore how Mid Staffordshire has changed the provisions in this Bill?

I want to refresh the Minister’s memory of our previous debates on the Secretary of State’s powers. The explanatory notes say that this provision is extending the Secretary of State’s powers.

Jeremy Lefroy: I rise to underline the hon. Gentleman’s point. One of the real problems that my constituents faced during that time was that they did not know who to go to in the case of an emergency, as it then was. That needs clarification.

Derek Twigg: I am grateful for that intervention, which is why I raised the point. It is important to remind the Minister that my right hon. and hon. Friends and I have raised serious concerns about the proposed changes to accountability, particularly to the accountability of the Secretary of State’s Department. A point was made about the ability of Ministers to intervene in matters raised by MPs and whether MPs would be told to go to speak to the NHS board or consortia. It would
be interesting to hear what the Minister has to say about the emergency powers, but he should not forget that some of the powers, as they currently stand, are being transferred elsewhere.

In his responses, the right hon. Member for Chelmsford, whom I congratulate on his elevation to the Privy Council, has kept telling us that the Bill is about freeing up the NHS from bureaucracy, reducing political interference and liberating providers. In the clause, however, we see that the Secretary of State’s powers, which have been described by some as draconian, have been extended. Will the Minister give us more information about the extent of the Secretary of State’s powers under the clause and what has changed from the previous situation?

Paul Burstow: I would probably be straying beyond the bounds of the clause if I were to describe the architecture in respect of accountability for the day-to-day running of the NHS. The clause relates to the exceptional circumstances of an emergency. That is the context in which the hon. Gentleman wants further information, and I will be more than happy to try to supply some of that.

Let me go through a few issues that will illuminate the position. There is concern about the circumstances in which the Secretary of State might use the powers. The Secretary of State would declare an emergency only where it was appropriate to do so—for example, to ensure that a service under the Act continued to be provided. In the event of a major flood affecting—

Derek Twigg: Will the Minister give way?

Paul Burstow: Let me develop the thread of my speech a little further and then I will be more than happy to take an intervention. In the event of a major flood affecting an area, as happened in Cumbria, a hospital trust in a neighbouring area may be directed to treat patients transferred from hospitals in the affected area. The ongoing Exercise Watermark, which relates to flooding, would be a case in point.

I shall give another example to develop the point and then give way. A transient power failure in a hospital would initiate a local emergency plan on a site, but that would not require the emergency declaration by the Secretary of State. However, a longer-term cessation of power that rendered the local NHS unable to maintain essential NHS services for patients might require a direction from the Secretary of State for mutual assistance from other areas. Those are a few examples.

Derek Twigg: I apologise for trying to jump in too early, because the Minister was developing his point. In the event of the failure of an NHS trust—we can go back to the Mid Staffordshire case—how would failure be determined under the Secretary of State’s powers? I apologise if the Minister was coming to that point, but it is important because failure might be subjective in some instances.

Paul Burstow: If I may say so, that is not what the clause is about. It is not about describing or dealing with the failure of providers in the sense that we might in other contexts. It is about circumstances in which an emergency requires the marshalling of NHS resources in a particular way that requires clear command and control. Flooding is a good example. We are talking about circumstances in which, for one reason or another, there is a need to ensure that services are organised to deliver—where there has been a failure of the electricity supply or flooding, for example. If the hon. Gentleman wants to intervene again, I ask him to be clear about what he means by failure for this purpose, so that I can be as helpful as possible.

Derek Twigg: I think that I was asking the Minister to explain that in more detail because we are not clear about it. Let me put it this way. Let us think of the clinical care of patients and take the example of an NHS trust where people may have died in greater numbers than one or two and nothing has been done by the board or by Monitor. What would the Secretary of State’s position be?

Paul Burstow: Let me try to deal with that by describing what would constitute a relevant emergency for the purposes of the clause. A relevant emergency, to which these duties apply, includes any emergency that might affect a body to which the duty to be properly prepared applies, whether by increasing the need for services that it commissions or provides or in any other way. The emergency preparedness provisions therefore apply in relation to an emergency in which the body in question may be asked to assist other NHS bodies or other public authorities responding to that emergency, as well as one that directly affects its local services.

I shall give some examples. An NHS trust would need to plan to protect its services in case of fire, flood or power failure—the examples that I have already given.

Grahame M. Morris: In relation to that list of examples, in the event of the failure of a foundation trust, would the Secretary of State exercise emergency powers, for example to instruct the neighbouring trust to take on those responsibilities?

Paul Burstow: Let me be absolutely clear—that is not the purpose of the clause. There are other clauses in the Bill in which the issues around the failure regime and so on will be dealt with, but they are not dealt with in this clause. This clause is about dealing with civil emergencies of one sort or another, where there is a need to have clear command and control to ensure that public resources are directed appropriately through the NHS to address a civil emergency. I hope that that answers the question—I am answering it as clearly as I possibly can.

I am not sure that I have addressed the questions put by the hon. Member for Halton. If I have not done so, he should intervene again, because I am anxious to ensure that this clause, which is about ensuring that we have a robust set of arrangements in the event of an emergency—

Derek Twigg: Just for the record, if a Mid Staffordshire trust situation occurred today the Secretary of State still could not intervene?

The Chair: I would be appreciative, Mr Burstow, if you did not invite colleagues to intervene. [Laughter.]
Paul Burstow: The reason that I did so, Mr Hancock, is that I want to ensure that, before we finish our debate on this clause, hon. Members are clear about the intention behind it. Through this clause, some hon. Members are trying to explore—quite understandably—what the failure regime might look like, how it would work and the role of the Secretary of State. What I am trying to say to them, as clearly as I can, is that this clause is not about the failure regime.

The hon. Gentleman was talking about the Mid Staffordshire trust. What happens in a case such as Mid Staffordshire is that the CQC is responsible for safeguarding essential levels of quality and safety. In the existing system today, that responsibility sits with the CQC and not with the Secretary of State. That is what the hon. Gentleman’s question was about—“What happens now?” And that responsibility would not sit with the Secretary of State in the future. However, this clause is not about those matters.

Derek Twigg: I will intervene on the Minister one last time, just to get some clarity. So the Bill does not change the situation. We can go through all the various bodies that will have responsibility—Monitor, the CQC, whatever. The same is true of the bodies that are in place currently. However, if those bodies all miss a problem and do not deal with it, the Secretary of State still cannot come in and make a direction in a situation such as the one in the Mid Staffordshire trust. Is that right?

Paul Burstow: That question does not apply to this clause. It is an important question and it is one of the reasons why, at earlier stages in the consideration of the Bill, I indicated the Government’s desire and intention to listen to and act on the recommendations of the Francis inquiry. It is also why I have made it very clear on the record today that we already have provisions, through the arrangements for the CQC, to safeguard essential standards of safety and quality. Those provisions were legislated for in the last Parliament by an Administration of which the hon. Gentleman was a member and they provide those safeguards to deal with situations such as the one in Mid Staffordshire. We are willing to consider other changes in the light of Mid Staffordshire, but this clause is not about that issue.

Having said that, I hope that this clause, as amended, can stand part of the Bill.

Question put and agreed to.

Clause 39, as amended, accordingly ordered to stand part of the Bill.

Clause 45 ordered to stand part of the Bill.

Schedule 4

PART 1: AMENDMENTS TO THE NATIONAL HEALTH SERVICE ACT 2006

Paul Burstow: I beg to move amendment 225, schedule 4, page 238, line 3, at end insert—

“Omit Chapter 5B of Part 2 (trust special administrators: Primary Care Trusts).”.

The Chair: With this, it will be convenient to discuss Government amendments 494 and 226 to 254.

I ask the Committee’s indulgence. When we come to vote on these Government amendments, members should decide whether we take the last group of amendments as a collective group or as individual amendments.

Paul Burstow: The amendments are all minor and technical changes to the National Health Service Act 2006, as a result of changes made elsewhere in the Bill. The vast majority are consequent on the abolition of primary care trusts and strategic health authorities, which is provided for in clauses 28 and 29 of part 1 of the Bill, which we have already considered.

As such, most of these amendments are concerned with removing references to and definitions containing “primary care trust”. For example, amendment 252 removes “primary care trust” from the definition of health service hospital. In addition, a number of these amendments remove references to strategic health authorities. For example, amendment 226 removes strategic health authorities from the list of bodies in section 78 that the Secretary of State is allowed to direct in the event of a failure. References to these bodies will no longer be needed once they are abolished by the Bill.

2.30 pm

Some of these amendments insert references to the new bodies established by the Bill, including the NHS commissioning board and consortia where appropriate. For example, amendment 234 to section 123 transfers some ophthalmic functions previously held by PCTs to the NHS commissioning board, in line with changes in primary care elsewhere in the Bill.

Amendments 236 to 241 ensure that the amendments to the National Health Service Act 2006 currently in the Bill extend powers to request documents—for investigative purposes—from contractors providing services for the Secretary of State’s public health functions, as well as those of local authorities. They remove references to local authorities in the definition of the Secretary of State’s security management functions. The existing version of the Bill incorrectly suggests that those functions would be extended to local authorities.

Amendment 238 also ensures that amendments to the 2006 Act that are currently in the Bill are extended to require the production of documents for contractors providing services for the purpose of the Secretary of State’s health functions. While the amendments to this schedule and the next are numerous, they are of a minor and inconsequential nature, and I hope that hon. Members are reassured that they are essential to the functioning of the Bill and all related legislation. For those reasons, I ask the Committee to accept these amendments to schedule 4.

Derek Twigg: Are we taking Government amendments 226 to 254?

The Chair: We can speak to the whole group collectively. We will vote on them separately.

Derek Twigg: I have a very simple question. The reference in amendment 236 is to “NHS services”. Will the Minister explain what is meant by “NHS services”? If he cannot answer now I am happy for him to write to me, but I would like an explanation. To make it clear, when I come to speak on the amendments to the next
clause there will be a number of issues about the naming of services—whether they are NHS services or health service provisions—and I will ask the Minister some specific questions. Maybe he will be able to answer at that point.

Paul Burstow: I will make sure that I do. Amendment 225 agreed to.

Paul Burstow: Before we deal with the amendments to be made formally, may I very quickly answer the question that was asked? Any service funded by the NHS would be covered by the definition “NHS services”.

Amendments made: 494, in schedule 4, page 238, line 25, at end insert—

'(1) In subsection (2A), in paragraph (b) for “paragraphs (a) to (h)” substitute “paragraphs (za) to (h)”.

Amendment 226, in schedule 4, page 239, line 23, at end insert—

'In section 78 (directed partnership agreements), in subsection (3)—

(a) omit paragraph (a), and

(b) omit paragraph (b).

Amendment 227, in schedule 4, page 239, leave out lines 38 to 41 and insert—

'(a) any facilities the provision of which is arranged by the Board or (as the case may be) the consortium under this Act,

(b) any facilities of the Board or (as the case may be) the consortium, and

(c) the services of persons employed by the Board or (as the case may be) the consortium.

Amendment 228, in schedule 4, page 239, line 41, at end insert—

'(1) In subsection (4) after “carry out” insert “, and the Board or a commissioning consortium may arrange for the carrying out of,”.

Amendment 229, in schedule 4, page 240, line 16, at end insert ‘and

() any facilities of the Board or (as the case may be) the consortium.

Amendment 230, in schedule 4, page 240, line 21, at end insert—

'(1) at the end of paragraph (c) insert “or”, and.

Amendment 231, in schedule 4, page 240, line 22, at end insert ‘and the word “or” immediately preceding it.

Amendment 232, in schedule 4, page 240, line 29, at end insert—

'(9) The Board or a commissioning consortium may arrange to make available to local authorities the services of persons providing services pursuant to arrangements made under this Act by the Board or (as the case may be) the consortium, so far as is reasonably necessary and practicable to enable local authorities to discharge their functions relating to social services, education and public health.

Amendment 233, in schedule 4, page 240, line 40, at end insert ‘and,

() in paragraph (b) at the beginning insert “where the person is the Secretary of State and is not the officer’s employer,”.

Amendment 234, in schedule 4, page 247, line 5, at end insert—

'(1) subsection (7)(a) and (b).

Amendment 235, in schedule 4, page 256, line 4, leave out paragraph 101.

Amendment 236, in schedule 4, page 256, line 13, leave out paragraphs (b) to (g) and insert—

'(1) In paragraph (a) after (“NHS services”) insert “or in arranging for the provision of such services”,

(2) in paragraph (d) after “NHS services” insert “or with arranging for the provision of such services”, and

(3) in paragraph (f) after “NHS services” insert “or with arranging for the provision of such services”.

Amendment 237, in schedule 4, page 256, line 23, at end insert—

'(1) In subsection (2), for “section 28(6)” substitute “section 275(1)”.

Amendment 238, in schedule 4, page 256, line 30, leave out sub-paragraph (3) and insert—

'(1) After subsection (5) insert—

(5A) A “public health service contractor” means any person providing services of any description under arrangements made in the exercise of the public health functions of the Secretary of State or a local authority.

Amendment 239, in schedule 4, page 256, line 36, leave out sub-paragraphs (2) and (3) and insert—

'(1) In subsection (1)(a) after “health service provider” insert “, public health service contractor”.

(2) In subsection (3)(d) after “health service provider” insert “, public health service contractor”.

Amendment 240, in schedule 4, page 256, line 39, at end insert—

'In section 201 (disclosure of information), in subsection (3)(a) for “any of the Secretary of State’s functions” substitute “any of the functions of the Secretary of State, the Board, a commissioning consortium or a local authority.”

Amendment 241, in schedule 4, page 256, line 41, leave out sub-paragraphs (2) and (3) and insert—

'(1) In subsection (1) after “health service provider” insert “, public health service contractor”.

(2) In subsection (2)(a)—

(a) after “in relation to” insert “the Secretary of State, local authorities,”, and

(b) after “health service providers” insert “, public health service contractors.”.

Amendment 242, in schedule 4, page 257, line 5, at end insert—

'(1) Section 211 (acquisition, use and maintenance of property) is amended as follows.

(2) In subsection (4) for “A local social services authority” substitute “A local authority”.

(3) After that subsection insert—

(4A) In subsection (4), “local authority” has the same meaning as in section 2B.

Amendment 243, in schedule 4, page 257, line 26, after ‘appointed’ insert ‘under paragraph 10 of Schedule 1A’.

Amendment 244, in schedule 4, page 259, line 7, at end insert—

‘In section 234 (special arrangement as to payment of remuneration), omit subsection (4).’.

Amendment 245, in schedule 4, page 259, line 33, at end insert—

'(1) Section 242 (public involvement and consultation) is amended as follows.

(2) In subsection (1A)—

(a) omit paragraph (a), and

(b) omit paragraph (b).

(3) Omit subsections (4) and (5).’.
Amendment 246, in schedule 4, page 260, line 15, leave out paragraph 124 and insert—

(1) Section 258 (university clinical teaching and research) is amended as follows.

(2) In subsection (1)—

(a) for “The Secretary of State must exercise his functions under this Act” substitute “The functions under this Act of the Secretary of State, the Board and each commissioning consortium must be exercised”, and

(b) for “he” substitute “the Secretary of State, the Board or the consortium (as the case may be)”. 

(3) In subsection (2), in paragraph (a)—

(a) after “exercisable by” insert “the Board,”,

(b) after “a” insert “commissioning consortium,”,

(c) omit “Strategic Health Authority,”, and

(d) omit “Primary Care Trust,”.

Amendment 247, in schedule 4, page 260, line 40, leave out paragraph 127.

Amendment 248, in schedule 4, page 261, line 4, at end insert—

(1) Section 272 (orders, regulations, rules and directions) is amended as follows.

(2) In subsection (3) omit paragraph (d).

(3) In subsection (5) omit “a PCT order, or”.

Amendment 249, in schedule 4, page 261, line 5, leave out paragraph 128 and insert—

(1) Section 273 (further provision about orders and directions) is amended as follows.

(2) In subsection (3) for “by a Strategic Health Authority” substitute “by the Board”.

(3) In subsection (4)(c)(ii) omit “15,”.

Amendment 250, in schedule 4, page 261, line 7, leave out ‘275(1)’ and insert ‘275’.

Amendment 251, in schedule 4, page 261, line 8, at the beginning insert ‘( ) In subsection (1),’.

Amendment 252, in schedule 4, page 261, line 12, at end insert—

( ) In the definition of “health service hospital” omit “a Primary Care Trust,”.

Amendment 253, in schedule 4, page 261, line 20, at end insert—

( ) In subsection (3)—

(a) omit “or 15”,

(b) omit “Strategic Health Authority,” (in both places where it occurs), and

(c) omit “Primary Care Trust or” (in both places where it occurs).

Amendment 254, in schedule 4, page 261, line 23, at end insert—

(1) Section 276 (index of defined expressions) is amended as follows.

(2) Omit the entry relating to “NHS body”.

(3) Omit the entry relating to “PCT order”.

(4) After the entry relating to “provider, in relation to an NHS contract” insert—

“public health functions of the Secretary of State

public health functions of local authorities

section 1(2B)(a)

section 1(2B)(b)”.

—(Paul Burstow.)

Question proposed. That the schedule, as amended, be the Fourth schedule to the Bill.
NICE quality standards not being properly taken into account in commissioning can be addressed. In this area in particular, she has highlighted why those strengths will make a big difference to many of her constituents and mine.

I will write to my hon. Friend and members of the Committee on the specific details. It will be a useful example to work through on how the new arrangements will strengthen commissioning, so I undertake to do that.

Schedule 4, as amended, agreed to.

Schedule 5

PART 1: AMENDMENTS OF OTHER ENACTMENTS

Paul Burstow: I beg to move amendment 255, to schedule 5, page 261, line 25, at end insert—

Voluntary Hospitals (Paying Patients) Act 1936 (c. 17)

In section 1 of the Voluntary Hospitals (Paying Patients) Act 1936 (definitions)—

(a) in the definition of “voluntary hospital”, for “NHS foundation trust or a Primary Care Trust” substitute “an NHS foundation trust”; and

(b) omit the definition of “Primary Care Trust”.

The Chair: With this it will be convenient to discuss Government amendments 256 to 341 and Government new clause 2—Certification of death.

Paul Burstow: The amendments and the new clause add to the consequential amendments made to other enactments in schedule 5. The amendments are all consequential on the provisions of part 1, which we have discussed, and ensure that existing powers and duties in other legislation refer to the correct bodies in the new architecture.

Although the list of amendments is long, in the majority of cases they simply remove references to primary care trusts or strategic health authorities and insert references either to commissioning consortia and the commissioning board or to the Secretary of State or local authorities performing public health functions. In a few cases, we have removed references to PCTs and SHAs and not inserted any reference to the new bodies created by the Bill. That is usually because the new bodies will no longer be responsible for the activity. For example, unlike primary care trusts, the NHS commissioning board and commissioning consortia will not be providers of services but commissioners of services. That provides a split that has increasingly been established over the years.

Although I do not intend to speak in detail about each amendment, I would like to draw the Committee’s attention to amendment 260. I know that my hon. Friend the Member for Southport also wanted to speak to this amendment. He raised his concern about access under the access to public bodies provisions. Let me remind the Committee that during the discussions on the commissioning board, we promised that we would ensure that it was subject to the Public Bodies (Admissions to Meetings) Act 1960 and that is what this amendment does. I hope that we have reassured the Committee and that the amendments will be accepted.

Derek Twigg: This matter goes back to the question that I asked about the previous schedules. Perhaps it was an oversight, but the Minister did not cover it in his speech. He will probably understand that we have a great suspicion that the Government want to take the word “national” out of the national health service. [Interruption.] If the Minister will listen, he may be able to reassure me.

Amendment 312 refers to a person who is receiving NHS treatment. That seems fair enough. However, under amendment 332, the phrase “NHS services” is substituted with “health services”. Amendment 333 changes NHS functions to “health service functions” and amendment 335 substitutes an NHS function with a “health service function”. Amendment 337 states:

“In subsection (1) for ‘NHS services’ (in each place where it occurs) substitute “relevant health services”.

We have touched on this matter before in our debates, but now we are seeing significant changes to the wording, yet under amendment 312, we talk about “NHS treatment.”

Mr Kevin Barron (Rother Valley) (Lab): Does my hon. Friend think that the fact that 87 amendments have been tabled to this schedule is the sign of joined-up work in the Department prior to the publication of the Bill?

Derek Twigg: My right hon. Friend makes a very important point. He might remember my point of order when most of these amendments were submitted. We had to change the programme motion to include a debate on these amendments, for which we are grateful.

Many provisions make changes to various other Acts of Parliament, and that is important. It underlines the rush that there is to get this legislation through Parliament, which means that this is not good legislation. I could speak to a number of other amendments, but I am conscious that the Whips want to move on with business. Will the Minister tell us why those changes have been made and why the reference to the NHS is different in an earlier clause?

The Local Government Group has expressed concern about new clause 2. It said that the Coroners and Justice Act 2009 requires primary care trusts in England to appoint medical examiners to introduce a unified system of death certification for all deaths that does not require coroners, post mortems or inquests. Part 1 of schedule 5 and clauses 77 and 78 of the Bill have the effect of transferring the PCTs’ duties in regard to medical examiners to single and upper-tier local authorities, in line with the planned abolition of PCTs in 2013.

The Local Government Group has concerns about the uncosted change to the 2009 Act, which, it feels, has not been adequately consulted on or had a thorough impact assessment. The question is about how this additional requirement on councils squares with the commitment for no new burdens. This will be a wholly new requirement for local authorities and, given that the system will not be up and running before the abolition of PCTs, councils will be faced with the introduction of a largely untested process.

The Department of Health has anticipated the need for around 1,000 medical examiners, appointed by local authorities on a part-time basis. The new service is expected to impact on the NHS through the requirement...
of PCTs to recruit and train support officers and to monitor and manage performance and service, while ensuring that medical examiners are independent in how they exercise their professional judgment as medical practitioners. The requirement of PCTs is to provision office facilities, resources and access to information systems, all of which will now impact on local authorities and all of which have a cost.

2.45 pm

So what are the financial implications for councils? The initial impact assessment did not consider the cost implications for local authorities, other than for publicly held funerals, as the original intention was for the requirement of PCTs. They believe strongly that there should be a new impact assessment that considers the detailed implications for local authorities. The original impact assessment considered that the cost of introducing the medical examiners would be met in full from the fees paid by the public for death certificates.

In the proposed system, a flat fee would be payable irrespective of whether the body was buried or cremated, instead of the current situation in which those who choose to bury their relatives pay nothing and those who choose to cremate—some 70% of people—pay £160.50. It has been estimated that the cost of the new system will be less than the current one, so the total amount paid by the public should be less than at present. The flat fee should be less than the current fee for cremation. Currently, the total annual expenditure on cremation is estimated to be around £45 million.

The Local Government Group has consulted with several other member authorities who are sceptical about whether the introduction of the new role will really be cost-neutral, funded by fees from the public. Their concern is about funding and the additional cost burden, both in the short and long terms, and a potential unintended consequence may result from the fact that the public is asked to pay a much lower fee for deaths investigated by the coroners service and there may be increased pressure for coroners to investigate deaths. It is proposed that the fee for death certification will be set nationally. They are concerned that the national fee will not adequately reflect the differing costs of implementation at local level.

Local costs will be affected by issues such as rurality, demography and, for example, communities whose religious practice requires burial to take place as soon as possible after death. The concern is that in the current financial climate any new charge will be seen as a death tax imposed by councils.

Although local government does not oppose the idea in principle, as authorities already manage coroners and registrars, both of whom have had to work closely with medical examiners, it could make sense for them to be commissioned by local authorities and co-ordinated with the coroners and the registration service. They feel this issue needs to be addressed in a broader context, abrogating the totality of the new burdens associated with the health reforms. Furthermore, they seek agreement on planned consultation which will identify all the costs and implications for local authorities.

I will be interested to see what the Minister says about that. I had not realised the total impact on local authorities and wonder whether he would take the issues away and look at them again.

Paul Burstow: I thank the hon. Gentleman for his questions and I will try to address them in the order that he raised them. I will start with amendments 332 to 336 to provide the context in which the use of “health services” is appropriate. They amend provisions in schedule 5 that amend the Health Act 2009 and they relate to the NHS constitution. The amendments ensure that local authorities are added to the list of bodies who must have regard to the constitution.

The duty to have regard to the constitution covers the entire health service to reflect the fact that in the Bill we are transferring public health duties to local authorities, and it is because we want to ensure that those aspects of health that are discharged by local authorities are covered, that we are using the definition that we are. We are changing the reference to “health services” so we can ensure that we cover the comprehensive health service, which includes the NHS and public health. Both parts constitute the comprehensive health service, and we want to ensure that that is clear in terms of discharging duties under the NHS constitution. That is why the language is as it is.

The danger of retaining “NHS services” is that it would give the impression that health services provided and commissioned under the public health responsibility of local authorities were not part of that duty. I should have thought that hon. Members would want to ensure that the NHS constitution’s values, principles, and so on were being considered by local authorities when discharging their public health duties. That is the intent, and there is no sinister purpose behind it. It is about ensuring that we fulfil the ongoing obligation, which we believe we have, to a universal health service.

Amendments 337 to 339 amend provisions of the Health Act 2009 relating to quality. They ensure that quality accounts apply only to the provision of NHS services, not to public health services, and that Monitor, rather than strategic health authorities, will require providers to correct errors or omissions in their accounts.

Finally, the hon. Member for Halton raised a number of concerns about the examining service, on behalf of the Local Government Group. We have already embarked on a consultation about the public health responsibilities of local authorities and the resourcing of those, but to fulfil the hon. Gentleman’s request, I will write to him to ensure that we give him the best possible answer. I also want to make sure that we are properly consulting our colleagues in local government, so that we deal with any concerns that they have about a new burden that is not properly resourced. I can assure the hon. Gentleman that officials and Ministers in the Department for Communities and Local Government would be among the first to warn us of such a consequence, if it were there. I will, however, write to him on those points and with that, I hope the clauses can be amended in the way we recommend.

Amendment 255 agreed to.

Amendments made: 256, page 261, line 26, at end insert—

‘The National Assistance Act 1948 is amended as follows.’.

Amendment 257, page 261, line 32, at end insert—

‘In section 26 (provision of accommodation in premises maintained by voluntary organisations), in subsection (1C)—

(a) after “such” insert “commissioning consortium or”, and

(b) omit “Primary Care Trust or”.’.
Amendment 258, page 261, line 32, at end insert—

Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (c. 65)

In Part 1 of Schedule 2 to the Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (capacities in respect of which payments under Part 5 of the Act may be made, and paying authorities), in paragraph 15—

(a) in the first column (headed “capacity”), after “Officer of” insert “the National Health Service Commissioning Board, a commissioning consortium,”;

(b) in that column, omit “a Strategic Health Authority,”;

(c) in the second column (headed “paying authority”), after “The” insert “National Health Service Commissioning Board, commissioning consortium,”, and

(d) in that column, omit “Strategic Health Authority,”.

Amendment 259, page 261, line 32, at end insert—

Public Records Act 1958 (c. 51)

In Schedule 1 to the Public Records Act 1958 (bodies to which the Act applies), in paragraph 1—

(a) after “Authorities including” insert “the National Health Service Commissioning Board, commissioning consortium,”;

(b) after “records of trust property passing to” insert “the National Health Service Commissioning Board, a commissioning consortium,”;

(c) after “section 161 of the National Health Service (Wales) Act 2006” (in the second place it occurs) insert “or under section 274 of the Health and Social Care Act 2011”;

(d) after “or held by” insert “the National Health Service Commissioning Board, a commissioning consortium or”, and

(e) after “that Act, or” (in the second place where it occurs) insert “by virtue of section 2 and section 135 of, or paragraph 15 of Schedule 1A to, that Act, or under”.

Amendment 260, page 261, line 32, at end insert—

Public Bodies (Admission to Meetings) Act 1960 (c. 67)

In the Schedule to the Public Bodies (Admission to Meetings) Act 1960 (bodies to which the Act applies), in paragraph 1—

(a) omit paragraph (ea),

(b) before paragraph (g) insert—

( fa) the National Health Service Commissioning Board, except as regards the exercise of functions under the National Health Service (Service Committees and Tribunal) Regulations 1992, or any regulations amending or replacing those regulations,”, and

(c) omit paragraph (gg).

Amendment 261, page 261, line 32, at end insert—

Parliamentary Commissioner Act 1967 (c. 13)

In Schedule 3 to the Parliamentary Commissioner Act 1967 (matters not subject to investigation), in paragraph 8—

(a) in sub-paragraph (1)—

(i) after “Secretary of State by” insert “a local authority, the National Health Service Commissioning Board, a commissioning consortium,”;

(ii) omit “a Strategic Health Authority,”, and

(iii) omit “a Primary Care Trust”, and

(b) in sub-paragraph (2)—

(i) after “action taken by” insert “a local authority, the National Health Service Commissioning Board, a commissioning consortium or”,

(ii) omit “a Strategic Health Authority,”, and

(iii) omit “or Primary Care Trust”.

Amendment 262, page 261, line 32, at end insert—

Abortion Act 1967 (c. 87)

In section 1 of the Abortion Act 1967 (location of treatment for termination of pregnancy), in subsection (3) omit “a Primary Care Trust or”.

Amendment 263, page 261, line 32, at end insert—

Leasehold Reform Act 1967 (c. 88)

In section 28 of the Leasehold Reform Act 1967 (land required for public purposes)—

(a) in subsection (5), in paragraph (d)—

(i) after “to” insert “the National Health Service Commissioning Board, any commissioning consortium,”;

(ii) omit “any Strategic Health Authority,”, and

(iii) omit “, any Primary Care Trust”, and

(b) in subsection (6), in paragraph (c)—

(i) after “in the case of” insert “the National Health Service Commissioning Board, a commissioning consortium,”;

(ii) omit “a Strategic Health Authority,”, and

(iii) omit “, Primary Care Trust”.

Amendment 264, page 261, line 33, at end insert—

The Health Services and Public Health Act 1968 is amended as follows.

Amendment 265, page 262, line 13, at end insert—

Employers’ Liability (Compulsory Insurance) Act 1969 (c. 57)

In section 3 of the Employers’ Liability (Compulsory Insurance) Act 1969 (employers exempted from insurance), in subsection (2)(a)—

(a) after “City of London” insert “or a service for the provision of which the National Health Service Commissioning Board or a commissioning consortium has, by virtue of the National Health Service Act 2006, a duty or power to make arrangements”,

(b) for “a Primary Care Trust or local Health Board are” substitute “a local Health Board is”,

(c) omit “Chapter 1 of Part 7 of the National Health Service Act 2006, or”, and

(d) omit “Primary Care Trust or”.

Amendment 266, page 262, line 13, at end insert—

Local Authority Social Services Act 1970 (c. 42)

In Schedule 1 to the Local Authority Social Services Act 1970 (social services functions) in the entry relating to the Children Act 1989, in the column headed “nature of functions”—

(a) after “accommodated” insert “pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006”, and

(b) omit “, Primary Care Trust established under section 18 of the National Health Service Act 2006."

Amendment 267, page 262, line 13, at end insert—

Chronically Sick and Disabled Persons Act 1970 (c. 44)

(1) Section 17 of the Chronically Sick and Disabled Persons Act 1970 (separation of younger from older patients) is amended as follows.

(2) In subsection (1) for “The Secretary of State” substitute “The Welsh Ministers.”
(3) In subsection (2)—
(a) for “The Secretary of State” substitute “The Welsh Ministers”;
(b) for “each House of Parliament” substitute “the National Assembly for Wales”;
(c) for “as he considers” substitute “as they consider”, and
(d) for “in him” substitute “in them”.

Amendment 269, page 262, line 13, at end insert—

Local Government Act 1972 (c. 70)
In section 113 of the Local Government Act 1972 (placing of staff of local authorities at disposal of certain persons)—
(a) in subsection (1A)—
(i) after “with” insert “the Secretary of State, the National Health Service Commissioning Board,”,
(ii) after “Local Health Board,” (in each place where it occurs) insert “commissioning consortium,”,
(iii) omit “Primary Care Trust,” (in each place where it occurs),
(iv) in paragraph (a), after “disposal of” insert “the Secretary of State, the National Health Service Commissioning Board,”, and
(v) in paragraph (b), after “employed by” insert “the Secretary of State, the National Health Service Commissioning Board,”, and
(b) in subsection (4)—
(i) after “above”, insert “Secretary of State” means the Secretary of State in relation to the exercise of functions under section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, the National Health Service Act 2006,”,
(ii) before “NHS trust”” insert “commissioning consortium means a commissioning consortium established under section 14D of the National Health Service Act 2006, and”, and
(iii) omit the words from “and “Primary Care Trust”” to the end.’.

Amendment 270, page 262, line 13, at end insert—
House of Commons Disqualification Act 1975 (c. 24)
In Part 3 of Schedule 1 to the House of Commons Disqualification Act 1975 (offices disqualifying for membership of the House)—
(a) omit the entry relating to the chairman or any member of a Primary Care Trust,
(b) in the entry relating to the chairman or any member of any Strategic Health Authority or Special Health Authority, omit “Strategic Health Authority, or”, and
(c) at the appropriate place insert—
“Chairman or non-executive member of the National Health Service Commissioning Board.”.

Amendment 271, page 262, line 13, at end insert—
Acquisition of Land Act 1981 (c. 67)
The Acquisition of Land Act 1981 is amended as follows.
In section 16 (land excluded from compulsory purchase), in subsection (3)—
(a) after paragraph (a) insert—
“(aa) the National Health Service Commissioning Board;
(ab) a commissioning consortium established under section 14D of the National Health Service Act 2006,”,
and
(b) omit paragraph (c).
In section 17 (special parliamentary procedure applying to compulsory purchase orders concerning certain land), in subsection (4) in the definition of “statutory undertakers”—
(a) omit paragraph (ad), and
(b) before paragraph (b) insert—
“(ae) the National Health Service Commissioning Board,
(af) a commissioning consortium established under section 14D of the National Health Service Act 2006,”.

Amendment 272, page 263, line 32, at end insert—
‘Public Health (Control of Disease) Act 1984 (c. 22)
In section 13 of the Public Health (Control of Disease) Act 1984 (regulations for control of certain diseases), in subsection (4)(a)—
(a) omit “Strategic Health Authorities,”, and
(b) omit “, Primary Care Trusts”.

Amendment 273, page 263, line 33, at end insert—
The Dentists Act 1984 is amended as follows.
In section 26B (guidance for dentists), in subsection (8) omit paragraph (a).
In section 36M (guidance for dental care professionals), in subsection (8) omit paragraph (a).

Amendment 274, page 263, line 36, at end insert—
In section 50D (rules: consultation), in subsection (4) omit paragraph (a).

Amendment 275, page 263, line 39, at end insert—
In section 2 (rights of authorised representatives of disabled persons)—
(a) in subsection (5) in paragraph (a)—
(i) after “hospital accommodation” (in the first place it occurs) insert “provided pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006 or”,
(ii) for “the Secretary of State under section (3)(1)(a)” substitute “the Secretary of State under section 2A or 2B”, and
(iii) omit “by a Primary Care Trust established under that Act.”,
(b) in subsection (7) in paragraph (a), after “provision of services” insert “, or the arrangement for the provision of services”, and
(c) in subsection (9) in the definition of “health authority”, in paragraph (a)—
(i) after “means” insert “the National Health Service Commissioning Board, a commissioning consortium or”,
(ii) omit “a Strategic Health Authority,”, and
(iii) omit “or a Primary Care Trust.”.

Amendment 276, page 263, line 42 [Schedule 5], at end insert ‘, and

(i) in the definition of “the managers”—
(a) in paragraph (a) for “, an NHS foundation trust or a Primary Care Trust” substitute “or an NHS foundation trust”,
(ii) in the words following paragraph (a)(ii) after “means the” insert “Secretary of State where the Secretary of State is responsible for the administration of the hospital, or means the”,
(iii) in those words omit “Strategic Health Authority,”, and
(iv) omit paragraph (bb).

Amendment 277, page 263, line 43 [Schedule 5], after ‘Parliament,’ insert ‘—

(i) in subsection (1ZA) omit “subsection (1ZB) extends to England and Wales only and”, and’. 

Amendment 278, page 263, line 43, at end insert—
‘In section 16 (interpretation), in subsection (1)—
(a) omit the definition of “Primary Care Trust”, and
(b) omit the definition of “Strategic Health Authority”.’.
Amendment 279, page 263, line 43, at end insert—

'Dartford-Thurrock Crossing Act 1988 (c. 20)

In section 19 of the Dartford-Thurrock Crossing Act 1988 (exemption from tolls), in paragraph (b), in subsection (2)—
(a) omit “a Strategic Health Authority established under section 13 of the National Health Service Act 2006,”;
(b) for “that Act” substitute “the National Health Service Act 2006,”;
and
(c) omit “a Primary Care Trust established under section 18 of the National Health Service Act 2006,”.

Amendment 280, page 263, line 43, at end insert—

'Copyright, Designs and Patents Act 1988 (c. 48)

In section 48 of the Copyright, Designs and Patents Act 1988 (material communicated to the Crown in the course of public business), in subsection (6)—
(a) after “the National Health Service and Community Care Act 1990,” insert “the National Health Service Commissioning Board, a commissioning consortium established under section 14D of the National Health Service Act 2006,”;
and
(b) omit “a Primary Care Trust established under section 18 of the National Health Service Act 2006,”.

Amendment 281, page 263, line 43, at end insert—

'Health and Medicines Act 1988 (c.49)

In section 7 of the Health and Medicines Act 1988 (extension of powers for financing health service), in subsection (3)(i) omit the words from the second “the” to “trust, or”.

Amendment 282, page 263, line 43, at end insert—

'Road Traffic Act 1988 (c.52)

In section 144 of the Road Traffic Act 1988 (exception to requirement for third party insurance), in subsection (2)(da) omit “by a Primary Care Trust established under section 18 of the National Health Service Act 2006”.

Amendment 283, page 264, line 2, at end insert—

'In section 21 (provision of accommodation for children in police protection etc), in subsection (3)—
(a) for “Secretary of State,” substitute “Secretary of State or”;
(b) omit “or a Primary Care Trust” (in each place where it occurs), and
(c) after “arrangements made by” insert “the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006 or”.

In section 24 (persons qualifying for advice and assistance), in subsection (2)—
(a) in paragraph (d), in sub-paragraph (i) omit “or Primary Care Trust”, and
(b) in that paragraph, in sub-paragraph (ii) after “provided” insert “pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006 or”.

Amendment 284, page 264, line 9, at end insert—

'In section 29 (recoupment of cost of providing services), in subsection (8) in paragraph (c)—
(a) for “Secretary of State,” substitute “Secretary of State or”;
(b) omit “or a Primary Care Trust” (in both places where it occurs),
(c) after “arrangements made by” insert “the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006 or by”, and
(d) omit “a Strategic Health Authority.”.

Amendment 285, page 264, line 16, at end insert—

'In section 80 (inspection of children’s homes)—
(a) in subsection (1), in paragraph (d)—
(i) omit “Primary Care Trust,”; and
(ii) after “NHS foundation trust” insert “or pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006”,
(b) in subsection (5), in paragraph (e) omit “Primary Care Trust,”, and
(c) after that paragraph insert—
“(ea) person providing accommodation for a child pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006”.

In section 85 (children accommodated by health authorities)—
(a) in subsection (1) omit “Primary Care Trust,”, and
(b) after subsection (2) insert—
“(2A) Where a child is provided with accommodation—
(a) by a body which is not mentioned in subsection (1), and
(b) pursuant to arrangements made by the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006,
subsections (1) and (2) apply in relation to the Board or (as the case may be) the consortium as if it were the accommodation authority.”

In section 105 (interpretation), in subsection (1)—
(a) before the definition of “community home” insert—
“(commisioning consortium) means a commissioning consortium established under section 14D of the National Health Service Act 2006”;
(b) omit the definition of “Primary Care Trust”, and
(c) the definition of “Strategic Health Authority”.

Amendment 286, page 264, line 16, at end insert—

'National Health Service and Community Care Act 1990 (c. 19)

The National Health Service and Community Care Act 1990 is amended as follows.

In section 47 (assessment of needs for community care services), in subsection (3)—
(a) before paragraph (a) insert—
“(za) that there may be a need for the provision to that person, pursuant to arrangements made under the National Health Service Act 2006 by such commissioning consortium as may be determined in accordance with regulations, of any services,”;
(b) in paragraph (a), omit “Primary Care Trust or”;
(c) in that paragraph omit “the National Health Service Commissioning Board or a commissioning consortium under the National Health Service Act 2006 or”; and
(d) in the text following paragraph (b), omit “Primary Care Trust,” (in both places where it occurs), and
(e) in that text, before “Health Authority” (in both places it occurs) insert “commissioning consortium.”.

In section 49 (transfer of staff to local authorities), in subsection (4)(b)—
(a) omit “Strategic Health Authority,”, and
(b) omit “Primary Care Trust,”.
In section 60 (removal of crown immunities), in subsection (7)—
(a) in paragraph (a) omit the words from “a Strategic” to “2006 or”, and
(b) in paragraph (aa) for “that Act” substitute “the National Health Service Act 2006”.

Amendment 287, page 264, line 16, at end insert—
 Access to Health Records Act 1990 (c. 23)
The Access to Health Records Act 1990 is amended as follows.
In section 1, in subsection (2) (meaning of “holder” in relation to a health record)—
(a) in paragraph (a)—
(i) for “a Primary Care Trust or” substitute “the National Health Service Commissioning Board or a”, and
(ii) omit “Trust or”, and
(b) in paragraph (aa)—
(i) for “a Primary Care Trust, Strategic Health Authority or” substitute “the National Health Service Commissioning Board or a”, and
(ii) omit “Trust, Authority or”.
In section 11 (interpretation)—
(a) in the definition of “health service body”, in paragraph (a)—
(i) omit “Strategic Health Authority,”,
(ii) for “Local” substitute “or Local”, and
(iii) omit “or Primary Care Trust”,
(b) omit the definition of “Primary Care Trust”, and
(c) omit the definition of “Strategic Health Authority”.

Amendment 288, page 264, line 16, at end insert—
 London Local Authorities Act 1991 (c. xiii)
In section 4 of the London Local Authorities Act 1991 (interpretation) in the definition of “establishment for special treatment”, in paragraph (d) for “by a Primary Care Trust established under section 18 of the National Health Service Act 2006” substitute “by the National Health Service Commissioning Board or a commissioning consortium pursuant to arrangements made under the National Health Service Act 2006.”.

Amendment 289, page 264, line 16, at end insert—
 Trade Union and Labour Relations (Consolidation) Act 1992 (c. 52)
In section 279 of the Trade Union and Labour Relations (Consolidation) Act 1992 (health service practitioners)—
(a) in subsection (1), in paragraph (a) for “a Primary Care Trust” substitute “the National Health Service Commissioning Board”;
(b) in subsection (2), in paragraph (a) for “a Primary Care Trust, Strategic Health Authority or” substitute “the National Health Service Commissioning Board or a”,
(c) in paragraph (b) of that subsection, for “a Primary Care Trust or” substitute “the National Health Service Commissioning Board or a”, and
(d) in that paragraph, for “entered into by him with a Primary Care Trust” substitute “entered into by him with the National Health Service Commissioning Board”.

Amendment 290, page 264, line 16, at end insert—
 Charities Act 1993 (c. 10)
In section 43A of the Charities Act 1993 (annual audit etc. of English NHS charity accounts) in subsection (7), in the definition of “English National Health Service charity”—
(a) omit paragraph (a),
(b) omit paragraph (b),
(c) before paragraph (c) insert—
“(ba) the National Health Service Commissioning Board;
(bb) a commissioning consortium;”,
(d) after that paragraph insert—
“(ca) trustees for the National Health Service Commissioning Board appointed in pursuance of paragraph 11 of Schedule A1 to the National Health Service Act 2006;
(cb) trustees for a commissioning consortium appointed in pursuance of paragraph 10 of Schedule 1A to the National Health Service Act 2006,”;
(e) omit paragraph (e).

Amendment 291, page 264, line 20, at end insert—
 Health Authorities Act 1995 (c. 17)
In Schedule 2 to the Health Authorities Act 1995 (property, rights and liabilities), in paragraph 2—
(a) in sub-paragraphs (1), (2), (6) and (7) omit “Primary Care Trust,”,
(b) in sub-paragraphs (1), (2), (6) and (7) omit “Strategic Health Authority,”.

Amendment 292, page 265, line 6, at end insert—
 Housing Grants, Construction and Regeneration Act 1996 (c. 53)
In section 3 of the Housing Grants, Construction and Regeneration Act 1996, in subsection (2)(f) (persons ineligible for grants)—
(a) at the beginning insert “the National Health Service Commissioning Board, a commissioning consortium,”,
(b) omit “a Strategic Health Authority,”,
(c) omit “Primary Care Trust.”.

Amendment 293, page 265, line 8, at end insert—
 ‘(1) Section 322 (duty of certain bodies to help local authorities) is amended as follows.
(2) In subsection (1)—
(a) after “another local authority,” insert “the National Health Service Commissioning Board, a commissioning consortium or”;
(b) omit “or a Primary Care Trust”, and
(c) for “the board, authority or trust” substitute “that body”.
(3) In subsection (2), for “An authority, a board or a trust” substitute “A body”.
(4) In subsection (3), in paragraph (a)—
(a) after “request is made of” insert “the National Health Service Commissioning Board, a commissioning consortium or”;
(b) omit “or a Primary Care Trust”, and
(c) for “that board or trust” substitute “that body”.
(5) In subsection (4)—
(a) for “an authority, a board” substitute “a local authority, the National Health Service Commissioning Board, a commissioning consortium or a Local Health Board”, and
(b) omit “or a trust”.

Amendment 294, page 265, line 19, at end insert—
 Audit Commission Act 1998 (c. 18)
In section 33 of the Audit Commission Act 1998, in subsection (8) (bodies not subject to certain Commission studies)—
(a) omit paragraph (a), and
(b) omit paragraph (b).

Amendment 295, page 265, line 19, at end insert—
 Data Protection Act 1998 (c. 29)
In section 69 of the Data Protection Act 1998 (meaning of “health professional”)—
(a) in subsection (1), in paragraph (k) for “such a body” substitute “a health service body”,
(b) in subsection (3), omit paragraph (a),
(c) in that subsection, before paragraph (b) insert—
“(aa) the Secretary of State in relation to the exercise of functions under section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, the National Health Service Act 2006,
(ab) a local authority in relation to the exercise of functions under section 2B or 111 of, or any of paragraphs 1 to 7B or 13 of Schedule 1 to, that Act,”; and
(d) in that subsection, omit paragraph (bb).’.
Amendment 296, page 265, line 21, at end insert—
‘In section 5 (authorities responsible for crime and disorder strategies), in subsection (1)(e) for “Primary Care Trust” substitute “commissioning consortium”’.

Amendment 297, page 266, line 2, at end insert—
‘In section 115, in subsection (2) (disclosure of information to relevant authorities)—
(a) omit paragraph (ea),
(b) after paragraph (f) insert—
“(fa) the National Health Service Commissioning Board;
(fb) a commissioning consortium;”’, and
(c) omit paragraph (g).’.

Amendment 298, page 266, line 2, at end insert—
‘Greater London Authority Act 1999 (c. 29)
In section 309E of the Greater London Authority Act 1999, in subsection (5) (bodies to be included among relevant bodies for purposes of Mayor of London’s health inequalities strategy)—
(a) omit paragraph (f),
(b) omit paragraph (g), and
(c) before paragraph (h) insert—
“(ga) the Secretary of State in relation to the exercise of functions under section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, the National Health Service Act 2006,
(gb) the National Health Service Commissioning Board,
(gc) any commissioning consortium (established under section 14D of the National Health Service Act 2006) for an area wholly or partly in Greater London.”.

Amendment 299, page 266, line 2, at end insert—
‘Health Act 1999 (c. 8)
The Health Act 1999 is amended as follows.
In section 61 (English and Scottish border provisions)—
(a) in subsection (2)—
(i) after “Secretary of State” insert “the National Health Service Commissioning Board”,
(ii) after “any” insert “commissioning consortium”,
(iii) omit “Strategic Health Authority”, and
(iv) omit “or Primary Care Trust”, and
(b) in subsection (3)—
(i) after “any” insert “commissioning consortium”, and
(ii) omit “Primary Care Trust”.
In Schedule 4 (amendments relating to Primary Care Trusts)—
(a) omit paragraphs 1, 74, and 86, and the cross-heading preceding each paragraph, and
(b) omit paragraphs 3(c), 82 and 85(2).’.

Amendment 300, page 266, line 2, at end insert—
‘Care Standards Act 2000 (c. 14)
In section 121 of the Care Standards Act 2000 (interpretation), in subsection (1) in the definition of “National Health Service body”—
(a) omit “a Strategic Health Authority,”, and
(b) omit “, a Primary Care Trust”.

Amendment 301, page 266, line 2, at end insert—
‘Government Resources and Accounts Act 2000 (c. 20)
(1) Section 14 of the Government Resources and Accounts Act 2000 (summarised accounts) is amended as follows.
(2) In subsection (1) omit “paragraph 7 of Schedule 15 to the National Health Service Act 2006 or”.
(3) Omit subsection (3).
(4) In subsection (4) for “ that subsection” substitute “subsection (1)”.

Amendment 302, page 266, line 2, at end insert—
‘Local Government Act 2000 (c. 22)
In section 21C of the Local Government Act 2000 (reports and recommendations of overview and scrutiny committees: duties of certain bodies), in subsection (6)—
(a) before paragraph (b) insert—
“(aa) the National Health Service Commissioning Board,
(ab) a commissioning consortium, or”.
(b) omit paragraph (c) and the preceding “or”.’.

Amendment 303, page 266, line 4, leave out paragraph 32 and insert—
‘In Part 3 of Schedule 1 to the Freedom of Information Act 2000 (NHS in England and Wales)—
(a) omit paragraph 36A,
(b) before paragraph 38 insert—
37A The National Health Service Commissioning Board.
37B A commissioning consortium established under section 14D of the National Health Service Act 2006.”, and
(c) omit paragraph 39.’.

Amendment 304, page 266, line 13, at end insert—
‘a commissioning consortium’.

Amendment 305, page 266, line 15, at end insert—
‘National Health Service Reform and Health Care Professions Act 2002 (c. 17)
The National Health Service Reform and Health Care Professions Act 2002 is amended as follows.
Omit Schedule 1 (English health authorities: change of name to Strategic Health Authorities).
Omit Schedule 2 (consequential amendments concerning the reallocation of functions to Primary Care Trusts).’.

Amendment 306, page 266, line 15, at end insert—
‘Adoption and Children Act 2002 (c. 38)
The Adoption and Children Act 2002 is amended as follows.
In section 4 (assessments etc for adoption support services), in subsection (9)—
(a) before paragraph (a) insert—
“(za) there may be a need for the provision to that person of services that may be provided pursuant to arrangements made by a commissioning consortium under the National Health Service Act 2006,”.
(b) in paragraph (a) omit “a Primary Care Trust”, and
(c) in the text following paragraph (b)—
(i) after “notify that” insert “commissioning consortium,”, and
(ii) omit “Primary Care Trust.”.
In section 8 (bodies which cannot be adoption support agencies), in subsection (2)—
(a) before paragraph (d) insert—
“(ca) the National Health Service Commissioning Board,”, and
(b) in paragraph (d)—
(i) omit “, Primary Care Trust”, and
(ii) before “(in Wales,” insert “, commissioning consortium”.”.”.
Amendment 307, page 266, line 15, at end insert—
‘Nationality, Immigration and Asylum Act 2002 (c. 41)
In section 133(4) of the Nationality, Immigration and Asylum Act 2002 (power of medical inspector to disclose information to health service bodies), in paragraph (a)—
(a) omit sub-paragraph (i),
(b) before sub-paragraph (ii) insert—
(ia) the National Health Service Commissioning Board,
(ib) a commissioning consortium established under section 12A of the National Health Service Act 2006,
(ic) a local authority in relation to the exercise of functions under section 2B or 111 of, or any of paragraphs 1 to 7B of, or any of Schedule 1 to, the National Health Service Act 2006,”, and
(c) omit sub-paragraph (iii).”.
Amendment 308, page 266, leave out lines 16 to 20.
Amendment 309, page 266, line 35, leave out ‘the Assembly’ and insert ‘the Welsh Ministers’.
Amendment 310, page 267, line 3, at end insert—
‘Sexual Offences Act 2003 (c. 42)
In section 42 of the Sexual Offences Act 2003 (care workers: interpretation) in subsection (5), in the definition of “National Health Service body”—
(a) after paragraph (b) insert—
“(ba) the Secretary of State in relation to the exercise of functions under section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, the National Health Service Act 2006,
(bb) a local authority in relation to the exercise of functions under section 2B or 111 of, or any of paragraphs 1 to 7B, or 13 of Schedule 1 to, the National Health Service Act 2006,”, and
(b) omit paragraph (c).”.
Amendment 311, page 267, line 4, at end insert—
“The Health and Social Care (Community Health and Standards) Act 2003 is amended as follows:”.
Amendment 312, page 267, line 7, at end insert—
‘In section 71 (reporting to Secretary of State and regulator)—
(a) in subsection (2), after “special measures” insert “or request another person to take special measures”, and
(b) omit subsections (3) and (4).
In section 148 (interpretation of Part 2), in the definition of “English NHS body”—
(a) omit paragraph (a),
(b) omit paragraph (b), and
(c) before paragraph (d) insert—
“(ca) the National Health Service Commissioning Board;
(cb) a commissioning consortium;”.
In section 160 (provision of information)—
(a) in subsection (1), after paragraph (g) insert—
“(h) if the injured person received NHS treatment pursuant to arrangements made by a commissioning consortium under section 3 or 3A of the National Health Service Act 2006, the commissioning consortium.”, and
In section 165 (power to apply provisions about recovery of charges to non-NHS hospitals), in subsection (3)(b)—
(a) omit sub-paragraph (i), and
(b) before sub-paragraph (ii) insert—
(ia) the National Health Service Commissioning Board,
(ib) a commissioning consortium,”.
Amendment 313, page 267, line 10, at end insert—
’( ) after subsection (6)(b) insert—
“(ba) the National Health Service Commissioning Board,”.
Amendment 314, page 268, line 18, at end insert—
‘In section 12A (establishment of children’s trust boards), after subsection (7) at the end insert “otherwise than by virtue of section 10(4)(da) or (db)”.
Amendment 315, page 270, line 18, at end insert—
‘Emergency Workers (Obstruction) Act 2006 (c. 39)
In section 1 of the Emergency Workers (Obstruction) Act 2006 (obstructing emergency workers)—
(a) in subsection (5), in paragraph (a)—
(i) after “Wales,” insert “the Secretary of State in the exercise of public health functions, the National Health Service Commissioning Board, a commissioning consortium,”, and
(ii) omit “, Primary Care Trust”, and
(b) after that subsection insert—
“(6) In subsection (5)(a) above “public health functions”—
(a) in relation to the Secretary of State, has the same meaning as in section 1(2B)(a) of the National Health Service Act 2006;
(b) in relation to a local authority, has the same meaning as in section 1(2B)(b) of that Act.”.
Amendment 316, page 270, line 18, at end insert—
‘National Health Service (Consequential Provisions) Act 2006 (c. 43)
In Schedule 1 to the National Health Service (Consequential Provisions) Act 2006—
(a) omit paragraphs 2( b), 30 (and the cross-heading preceding it), 47(b), 54(b), 90(c), 112(a), 125(c), 141(a), 170(b), 179(b)(iv), 180(c), 211(d), 228(a), 233(c), 234(c), 271(c) and 294 (which make amendments relating to Primary Care Trusts), and
(b) omit paragraphs 90(g), 125(e), 131(c)(i), 179(b)(i), 180(a)(i), 211(a), 228(c), 233(a), 234(a) and 271(e) (which make amendments relating to Strategic Health Authorities).”.
Amendment 317, page 270, line 18, at end insert—
‘NHS Redress Act 2006 (c. 44)
The NHS Redress Act 2006 is amended as follows.
In section 1, in subsection (3)—
(a) after paragraph (a) insert—
“(aa) the National Health Service Commissioning Board,
(ab) a commissioning consortium,”,
(b) omit paragraph (b),
(c) omit paragraph (c), and
(d) in paragraph (d) for “(b) or (c)” substitute “(aa) or (ab)”.’.
In section 18 (interpretation), in subsection (1) omit the definition of “designated Strategic Health Authority”.
Amendment 318, page 270, line 21, leave out paragraph 53 and insert—
‘In section 6 (regulated activity providers)—
(a) omit subsection (8D), and
(b) before subsection (9) insert—
(8E) The National Health Service Commissioning Board or a commissioning consortium does not make arrangements for another to engage in a regulated activity by virtue of anything the Board or the consortium does under section 12A or 12D, or regulations under 12B, of the National Health Service Act 2006 (direct payments for health services)”.’.
Amendment 319, page 270, line 31, at end insert—

( ) in subsection (2) after paragraph (b) (and before the “or”) immediately following it insert—

“(aa) the National Health Service Commissioning Board,”.

Amendment 328, page 272, line 38, after ‘consortium’ insert ‘under the National Health Service Act 2006 (including arrangements so made by virtue of section 7A or 12 of that Act)’.

Amendment 329, page 273, line 1, at end insert—

‘The Education and Skills Act 2008 is amended as follows.’.

Amendment 330, page 273, line 7, at end insert—

(a) omit paragraph (c),
(b) omit paragraph (d), and
(c) before paragraph (e) insert—

“(da) a commissioning consortium.”.

Amendment 331, page 273, line 18, leave out paragraph 73 and insert—

‘The Local Democracy, Economic Development and Construction Act 2009 is amended as follows.

In section 2 (duty to promote understanding of functions of certain public bodies)—

(a) in subsection (2), in paragraph (c) after “under” insert “section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, the National Health Service Act 2006 or”,
(b) in that subsection, after paragraph (e) insert—

“(ea) the National Health Service Commissioning Board, so far as exercising functions in respect of the principal local authority’s area;”.
(c) in subsection (3), after paragraph (k) insert—

“(ka) a commissioning consortium;”, and
(d) in that subsection—

(i) omit paragraph (i), and
(ii) omit paragraph (m).

In section 123 (partner authorities), in subsection (2)—

(a) after paragraph (h) insert—

“(ha) a commissioning consortium;”, and
(b) omit paragraph (i).

Amendment 332, page 273, line 24, at end insert—

( ) In each of the following provisions for “NHS services” substitute “health services”—

(a) the title to Part 1,
(b) section 2(3), (4)(a) and (b), (5)(a) and (b) and (7), and
(c) the definitions of “carers”, “patients” and “staff” in section 3(7).

Amendment 333, page 273, line 25, leave out ‘In section 2 (duty to have regard to NHS constitution),’ and insert—

( ) Section 2 (duty to have regard to NHS constitution) is amended as follows.

( ) In subsection (1), for “NHS functions” substitute “health service functions.”.

Amendment 334, page 273, line 30, at end insert—

“(cc) local authorities (within the meaning of section 2B of the National Health Service Act 2006);”.

Amendment 335, page 273, line 30, at end insert—

( ) In subsection (4)—

(a) before paragraph (a) insert—

“(za) provides health services under arrangements made by the National Health Service Commissioning Board or a commissioning consortium under or by virtue of section 3, 3A, 3B or 4 of, or Schedule 1 to, the National Health Service Act 2006,”.
(b) omit the word “or” at the end of paragraph (a), and
(c) after paragraph (b) insert ‘, or
(c) provides health services under arrangements made by a local authority for the purposes of its functions under or by virtue of section 2B or 6C(1) of, or Schedule 1 to, that Act.”.

( ) In subsection (5) for “subsection (4)(a) or (b)” substitute “subsection (4)(za), (a), (b) or (c)”.”.
Amendment 336, page 273, line 30, at end insert—
(1) Section 3 (availability and review of NHS constitution) is amended as follows.
(2) In subsection (3), omit paragraph (d).
(3) Omit subsection (8).
Amendment 337, page 273, line 31, leave out ‘In section 8 (duty of providers to publish information),’ and insert—
( ) Section 8 (duty of providers to publish information) is amended as follows.
( ) In subsection (1) for “NHS services” (in each place where it occurs) substitute “relevant health services”.
( ) Section 9 (duty of providers to publish information) is amended as follows.
( ) In subsection (3), omit paragraph (d).
Amendment 338, page 273, line 32, at end insert—
( ) For subsection (6) substitute—
“(6) In this section—
“health services” has the same meaning as in Chapter 1;
“relevant health services” means health services the provision of which is arranged by the National Health Service Commissioning Board or a commissioning consortium under or by virtue of section 3, 3A, 3B or 4 of, or Schedule 1 to, the National Health Service Act 2006 or under or by virtue of Parts 4 to 7 of that Act.”.
Amendment 339, page 273, line 32, at end insert—
‘In section 9 (supplementary provision about the duty to publish information), in subsection (3), for “a Strategic Health Authority” substitute “Monitor”.’.
Amendment 340, page 273, line 34, leave out paragraphs 77 and 78.
Amendment 341, page 274, line 3, at end insert—
‘The Equality Act 2010 is amended as follows.
In section 1 (public sector duty regarding socio-economic inequalities), in subsection (3)—
omit paragraph (h), and
omit paragraph (i).’.—[Paul Burstow.]
Schedule 5, as amended, agreed to.

Schedule 6

PART 1: TRANSITIONAL PROVISION

Paul Burstow: I beg to move amendment 342, in schedule 6, page 274, line 33, at end insert—
‘Directions under section 7 of the 2006 Act
1A (1) This paragraph applies if section 17 is commenced before section 29(1).
(2) Until section 29(1) is commenced, section 7(1) of the 2006 Act has effect as if after “Special Health Authority” there were inserted “or Primary Care Trust”.
(3) Sub-paragraph (4) applies in relation to any direction given under section 7(1) of the 2006 Act to a Primary Care Trust which has effect immediately before section 17 is commenced.
(4) Until section 29(1) is commenced, the direction continues to have effect as if given to the Primary Care Trust under section 7(1) of the 2006 Act (as it has effect by virtue of sub-paragraph (2)).
(5) Sub-paragraph (6) applies in relation to any direction given under section 7(2) of the 2006 Act to a Special Health Authority in respect of the functions of a Primary Care Trust which has effect immediately before section 17 is commenced.
(6) Until section 29(1) is commenced, the direction continues to have effect as if given to the Special Health Authority in respect of the functions of the Primary Care Trust under section 7(1) of the 2006 Act.
(7) Any reference in this paragraph to section 7(1) of the 2006 Act is a reference to that provision as amended by section 17.
1B (1) Sub-paragraph (2) applies in relation to any direction given under section 7(1) of the 2006 Act to a Special Health Authority which has effect immediately before section 17 is commenced.
(2) The direction continues to have effect on and after the commencement of that section as if given under section 7(1) of the 2006 Act (as amended by section 17).
These minor technical changes are necessary to clarify two points that are not made explicitly in the Bill. The first would ensure that the Secretary of State retains his powers of delegation in relation to primary care trusts, until their abolition. The second change would ensure that directions made to special health authorities under existing legislation can continue to be in force once clause 17, which relates to functions of special health authorities, commences. The provisions are important to ensure that the period of transition is as smooth as possible, and that everything continues to function as it should. I recommend, therefore, that the amendment stands part of the Bill.
Amendment 342 agreed to.
Schedule 6, as amended, agreed to.

Clause 46

ABOLITION OF HEALTH PROTECTION AGENCY

Paul Burstow: I beg to move amendment 343, in clause 46, page 60, line 5, at end insert—
‘( ) Schedule Abolition of the Health Protection Agency: consequential amendments (which makes amendments of other enactments in consequence of the provision made by this section) has effect.’.

The Chair: With this it will be convenient to discuss Government new schedule 1—Abolition of the Health Protection Agency: consequential amendments.

Paul Burstow: Clause 46 abolishes the Health Protection Agency and repeals the Health Protection Agency Act 2004. Amendment 343 and new schedule 1 are technical provisions that remove references to the Health Protection Agency from current enactments.

The abolition of the Health Protection Agency is an important step in the Government’s plan for unifying national health protection activity and creating a more transparent, responsive and accountable service under the Secretary of State. The Health Protection Agency is mentioned in primary legislation ranging from the Health and Safety Act Work etc. Act 1974 to the Employment Rights Act 1996, and in many cases the Secretary of State is already named in the relevant legislation and the reference to the Health Protection Agency simply needs to be omitted.

As discussed, clause 7 imposes on the Secretary of State a new general duty to protect the health of the people of England. The duty underpins a major component
of the new public health service. Public Health England, by making the Secretary of State directly accountable for protecting the health of the people of England. In many ways, the Health Protection Agency has done an outstanding job and it has established an international reputation for excellence. The efforts of staff will continue to the same high standard through Public Health England. The agency’s scientific expertise and ability to provide expert advice will continue. There will now be a clear line of sight to the Secretary of State for Health, however, on vital health protection and emergency preparedness issues. New arrangements will be much stronger and more efficient. I hope that the Committee will support the amendment.

Emily Thornberry: Clause 46 abolishes the Health Protection Agency as a statutory organisation and make the Secretary of State responsible for its functions, and we need to pause and think about the sense of that. I know that a number of organisations are anxious about it. There is concern that the Health Protection Agency will lose its independence and its impartiality, not only in fact but in the perception of the Health Protection Agency’s alternative structures. As the Minister has said, the agency has done an outstanding job and has an international reputation. If it is not broken, why is any attempt being made to fix it? On one hand, the Minister has argued for the importance of changing it to ensure greater transparency and accountability in the new structures. On the other hand—I know that the Government have this at the forefront of their mind in a lot of this legislation—it is important to avoid political involvement and to free the NHS from political interference.

There is obviously the potential, as there has been in the past, for a breakdown in public trust; we know about the BSE crisis and we know about the MMR vaccine crisis. The Royal College of Nursing in particular has asked me to point out that the Health Protection Agency is very different from the Department of Health. The Health Protection Agency is public and customer facing—it provides advice and information to the general public, to health professionals such as doctors and nurses and to national and local government—but the Department of Health is not naturally a public-facing body. That is causing some concern, which is why I am raising it today. Has the Minister given consideration to that, and to how the Department will carry out these new responsibilities?

The Health Protection Agency has a number of UK-wide functions. Will the Minister explain how those will be transferred to the devolved Administrations? I would also be grateful if the Minister explained the motivation behind that change and, in particular, why the Health Protection Agency will not be made a special health authority, which would have given it greater independence?

Emily Thornberry: I understand the hon. Gentleman’s perspective, but, from the perspective of the public and patients, it is a different body. It is not one that is seen as warm and welcoming to the public and to patients in the way that I am sure that the hon. Gentleman would want it to.

Paul Burstow: This is not necessarily an encouragement, but the Department of Health is the place that people write to when they have a concern about their experience in the health service. In some cases, that means that we will signpost it, but, in other cases, we will deal with it appropriately. In the case of reforms in public health, that further strengthens us.

The hon. Lady asked about the agency’s reputation for independence and how that might be affected. There is no reason why it should be. Public Health England will have all the functions of the Health Protection Agency along with its experts and scientists, many of whom, I am sure we all agree, are world class. There will continue to be expert advisory committees drawn from the scientific community through open recruitment, and the chief medical officer will continue to provide impartial and objective advice to Ministers and others.

The hon. Lady went on to ask about Health Protection Agency functions and how accountability will be improved. At a national level, there is a clear rationale for accountability for health protection resting with the Secretary of State and, through him, Parliament. That is the intention of the changes that the Bill makes. The nature of various threats to health range from infectious diseases to terrorist attacks, and they are not always amenable to individual or local action. They require a clear line of sight from the centre of Government down to local services, and we need a system that is more integrated and less dispersed than the present one. Abolishing the agency and conferring its responsibilities directly on to the Secretary of State will be a major step forward.

The Health Protection Agency does a good job, and its efforts will continue to the same high standards through Public Health England. Its scientific expertise and ability will continue to be available to provide independent expert advice. There will be a clear line of sight from the Secretary of State on vital health protection and emergency preparedness.

In essence, we want to see the Secretary of State and the Department of Health having a much sharper and clearer focus on public health than has historically been the case. That is an important, and up until this point oft-overlooked, area of responsibility in a comprehensive health service. By having clear outcomes and frameworks for the NHS, for public health and, indeed, social care, too, and also having that responsibility close to the Secretary of State, will allow us to be in a much better place to drive a public health agenda, of the sort that is necessary to address so many of the public health challenges that the country faces, right across Government. It is for those reasons that we are proceeding in this way. While concerns have been raised around implementation and transition in the consultations that we have undertaken; there have been no concerns about the principle of the direction of travel. For those reasons, I hope that the hon. Lady is reassured and that the amendments are accepted.

Amendment 343 agreed to.

Clause 46, as amended, ordered to stand part of the Bill.

3 pm

Paul Burstow: On the notion that the Department of Health is not a public-facing body, I must say, as a Minister in that Department, that it does not feel like that, both in terms of the amount of correspondence that the public quite rightly send in and the responses that Ministers give and that the hard-working team of correspondence officials discharge on our behalf.
Clause 60

FUNCTIONS UNDER THE COMPETITION ACT 1998

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

Mr Barron: I hope that I will not detain the Committee for too long, but I have been trying to get to the bottom of what “competition” means in relation to the Bill. We have been told on numerous occasions that the Bill is an extension of the legislation introduced in the past 10 years in which the previous Government introduced the independent sector to the national health service. That prompts the question—I see one or two Government Members nodding their head—why do we have to have all these clauses to introduce competition law if the Bill is just an extension of what has been happening over the past 10 years?

Earlier in our proceedings, I asked the Minister what he meant when he said on BBC television earlier this year, “It is going to be a genuine market. It is going to be a genuine competition.” His answer was that there is going to be competition in terms of quality. When we set off on this Bill, we looked at NICE’s role in quality standards, which I support. The spreading of best practice has been very poor inside the national health service, so, in that respect, I see where quality comes through from NICE’s laying down standards for patient pathways and having both commissioners and providers accept them. That seems to me to be a simple concept to accept.

Competition law is a little different. On Tuesday I asked a number of questions of the Minister on the Government’s intention for competition and the introduction of competition law. We see here that it is an introduction of competition law: it is not using the current framework, otherwise we would not have to have it in the Bill. I asked several questions. Our greatest problem, in a sense, is with the powers of Monitor. Those powers are described in the explanatory notes on clause 52, which say very little about how the shape of competition will work. The explanatory notes simply say that it will work “by promoting competition where appropriate and through regulation where necessary.”

On Tuesday we debated competition law and some of its different aspects. I asked a number of questions of the Minister, some of which he answered, but he was not taking interventions at the time because he wanted to get through answering questions that other Members and I had asked. The questions I asked of him related not to what is in the explanatory notes, but to what is in the White Paper that was published last July and explains the scope and powers of Monitor. I want very briefly to describe those questions. One question was on the powers Monitor will have to protect “essential assets; require monopoly providers to grant access to their facilities to third parties.”

The other question I asked him was on Monitor’s power to conduct “market studies and refer potential structural problems to the Competition Commission for investigation.”

In health care terms, this is the first time I have heard talk of the Competition Commission.

The Minister answered those two questions, in a form, but I would like to try to bring out of him exactly what he meant. He said:

“First, Monitor may need powers to protect essential assets to ensure continuity of essential services.”

That is absolutely true and is written in the Bill, which is right and proper. He then said:

“Secondly, the powers to grant access by third parties to a monopoly provider’s facilities would be used only in limited circumstances, when it was in patients’ interests, which could in the form of extended hours, more flexible access or more innovative services; the provider giving access would receive payment for doing so.”

There is a whole debate, not only in this Committee or in this House—it was debated in the Chamber yesterday, but I did not participate in that debate—but in political parties and in the different organisations that represent different aspects, both clinical and non-clinical, of the national health service. What exactly does this mean? What does bringing competition law into the NHS mean? With all due respect, “in limited circumstances” means absolutely nothing. It means very little to me that the new power the Bill will allow Monitor to exercise will be used “in limited circumstances”.

The Minister went on to the potential to address abuses by monopoly providers:

“First, our proposals explicitly recognise the role of monopoly providers in the NHS, which, to my mind, are not always a bad thing.”

In that debate I pointed out the hospital we can see through the window, which is a monopoly provider. He went on to say that “there are both natural monopolies, such as providers of specialist neurosurgery, and local hospitals that provide essential services where there are no alternative providers.”

Later, he spoke of taking action

“For example, where a provider refused to co-operate with GPs to provide integration of primary care within A and E.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 770.]

I have visited that type of establishment. We have had them for a number of years, and while it is true that they have, on occasion, been reluctant for GPs to endorse them because it would be a change away from the normal shape of general practice service in this country, why would we need these powers to bring in competition law if those are the examples? We are saying that they are an example of the potential abuse of a monopoly position.

Over many years we have been able to reshape the NHS at local level without ever having to bring competition law, or anything like it, into the equation. We are the Committee that should be looking in detail at the implications of this legislation for our constituents and the country. Going away from here on the basis of “in limited circumstances” does not satisfy me that, as a legislator, I can say to my constituents—or anybody else—that this legislation will not disrupt the NHS in the way that it has the potential to do.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): Is there not an added complication in this part of the Bill? If European competition law is a part of Monitor’s remit, would a monopoly provider, such as the one my right hon. Friend mentioned on Tuesday evening, potentially be subject to state aid rules if we were applying competition law to its full extent?
Mr Barron: Let me answer that very relevant question by explaining to the Committee. On Tuesday I said that we were all sent a brief on competition law by the NHS Confederation. An element I did not bring up then but will now is that

“Under the NHS reforms, Monitor will have the same powers as the OFT, in relation to competition in the provision of health services in England. Competition law regulates anti-competitive conduct, mergers and state aid. In relation to anti-competitive conduct, there are two main areas: [one is] (collusion) [and the other is] (monopoly)”. I am not convinced that monopoly will only be threatened “in limited circumstances”. We had no examples as far as the law is concerned— I am not a lawyer, but bringing competition law into the health service could open up every provision.

As I said on Tuesday, I accept entirely the existing issues around procurement. Competition law should be used there because it is a major way of protecting the public purse. There are good examples of where NHS procurement has not been as efficient for the taxpayer as it should have. There are many, many examples of that over many years. However, clinical services are entirely different. I am unsure about the implications around the issue of state aid and competition law—perhaps the Minister could tell us whether there are any implications concerning state aid, given that our health service is pretty unique in how it is funded?

As I said earlier, I do not want to detain the Committee, but I must go back to the question I posed to the Minister, which was not answered on Tuesday. It related to the White Paper published in July, which said:

“Monitor’s powers to regulate prices and license providers will only cover publicly-funded health services. However, its powers to apply competition law will extend to both publicly and privately funded healthcare, and to social care.”

Again, I pose the question to the Minister: what are the implications of that? What does it tell the Committee about whether competition law will be involved in every aspect of health and social care in this country? I entirely accept the issue about procurement, but this is about monopoly providers, which in general terms are hospitals, and about having access to them. I do not pose the question to scare anybody, but this is relevant. Even if all we get back is limited in terms of how this arrangement can work, I pose it to the Committee.

3.15 pm

There has been a great debate for 60 years about whether hospitals should have private wings. My local hospital does not have a private wing, but I have been into some that do. Some people who work in the NHS and many of our constituents would take strong exception to a current NHS hospital being told that it had to open a private wing because Monitor believed that that was a way to use the powers given to it by the Bill. I know that we are on competition law and not the powers of Monitor, but this is about the powers of Monitor. It has the power to look into the market and direct things if it feels that the market is being held up in any way. Competition law, quite frankly, does not reassure me about the decisions that will be taken.

As the hon. Member for Southport said in an earlier debate, much of our health care system is integrated, and has to be integrated at a regional or sub-regional level on occasion. That is how our NHS works. This is better left in the hands of people who know and not left in the hands of lawyers. I hope that the Minister can tell us exactly what the implications are for our NHS in years to come of bringing in competition law in this way in the Bill.

Graeme M. Morris: My view echoes that of my right hon. Friend. This is another cornerstone of the Bill. The provisions clause 60 and some subsequent clauses on functions under the 1998 Act are causing considerable concern, not only to my party and the public, but to many Members of the governing parties, and certainly to the medical profession.

Clause 60 gives Monitor powers under competition law that it can use concurrently with the Office of Fair Trading, as my right hon. Friend said. My understanding is that Monitor will identify market distortions or anti-competitive practices, and the Competition Commission will take appropriate corrective action. The application of competition law to health care is a major departure in terms of the clinical provisions and is of considerable concern. If the full weight of EU competition law applied to the NHS, as if it were a standard service industry, the process of privatisation, which Opposition members are concerned about and the Government have indicated that they are opposed to, could not only be accelerated but might become entirely irreversible.

My right hon. Friend said that a quarter of the Bill is dedicated to clauses dealing with competition. This seems to be a difficult concept to explain, but my principle concern is that in changing the structure and architecture of the NHS we are exposing the clinical areas to EU competition law. It is not so much about the drivers in the Bill, but the structural changes, and that is the issue of concern to Opposition Members and those further afield. It is important to read the clauses in conjunction with the impact assessment, and to note that the competition powers can be invoked where a private provider complains that a commissioner, such as a GP commissioner, is favouring an incumbent provider, such as a local NHS hospital. We touched on this when the hon. Member for Southport gave particular examples in his area, so I do not want to rehearse those.

The implication is that, on receipt of such a complaint, Monitor would be able to investigate local GPs with the threat of full enforcement powers, and the possibility of levying a penalty of up to 10% of their turnover where it determines that there has been anti-competitive practice. I accept that Monitor would do the investigation and would make the recommendations and that the Competition Commission would want to carry out the sanction. However, in cases like this—and even in extreme cases—it is conceivable that, under European competition law, there could be criminal offences. I am not suggesting that that is going to happen; it would be an extreme situation. However, even if that scenario is unlikely, just the prospect of it may be a useful weapon for the private providers who are seeking to gain entry to the market by exerting influence over local GPs to commission their services instead of the preferred NHS providers. Indeed, such threats would counteract any political pressure from the local community to save local services and local NHS hospitals.

I do not wish to go any further, but in part 1 of clause 15 there are also concerns about opening services to EU competition law.
Liz Kendall: My hon. Friends the Members for Rother Valley and for Easington both raised important issues about this clause. I would like to say some more about what the clause seeks to do and why I think that that is a huge problem, as do my hon. Friends. For the record, clause 60 gives Monitor concurrent functions with the Office of Fair Trading under part 1 of the Competition Act 1998. There has been much debate about this, both within this Committee and on the Floor of the House. The Act is applied and enforced by the OFT in a number of regulatory functions. I have found another one in the explanatory note with the Bill: it is not just telecoms, gas, electricity, water and railways but sewerage. So that is added to the mix.

Part 1 of the Act has two chapters. The first prohibits what are called undertakings from reaching certain agreements which prevent, restrict or distort competition, which include reaching agreements not only to fix prices but also to “share markets”.

Chapter 2 of part 1 of the Act prohibits undertakings from abusing a dominant position in the market, which include limiting production. Undertakings, as hon. Members will know, are defined in EU law as entities engaged in economic activity. I say EU law, because chapters 1 and 2 of part 1 of the Competition Act are modelled, as detailed in the explanatory notes, on articles 101 and 102 of the treaty on the functioning of the European Union. It is clear that these provisions are being generally applied to the NHS in primary legislation.

Monitor would have the same powers as the Office of Fair Trading to conduct investigations where it has reasonable grounds for suspecting that either of the prohibited areas that I have outlined have taken place in relation to health services in England. It would also have powers to impose remedies or penalties for those breaches. If I may clarify what some of my hon. Friends have said, the OFT’s powers include a power to fine businesses who are found to have broken the law up to 10% of their turnover. Third parties, including injured competitors, customers and consumer groups, can bring damages and claims against them. Individuals found to be involved in cartels can be fined and imprisoned for up to five years and directors of companies that breach prohibitions can be disqualified for up to 15 years. That is why it is important for us seriously to consider the implications for the NHS.

I want to get to the heart of the issue which Mr. Hancock rightly said should wait to be discussed until this clause. Members on this side of the Committee have not argued that this Bill extends the scope of competition law; we have argued that it extends the applicability of the law by extending it to the NHS. I say to the Minister that the national health service has explicitly become a market in which competition law has been added to primary legislation for the first time. The Minister is guaranteeing that it will be treated as a market and bodies will be treated as undertakings because that is enshrined in primary legislation for the first time. By introducing an economic regulator, the Government have made it clear that the NHS is being treated more as a market.

I would go further, however. As the private patient price cap is entirely removed from foundation trusts and they can make money from the private sector, they would be more likely to be considered undertakings. As there are no more primary care trusts or strategic health authorities as a management level of Government to cope with some of the results of patient choice, the Government’s policy is to move the NHS to be considered, as the Minister said in his “Newsnight” interview, more as a genuine market with genuine competition.

To be fair to the Minister, he recognised this in his comments to the Committee on Tuesday when he said: “UK and EU competition laws will increasingly become applicable…in a future where the majority of providers are likely to be classed as undertakings for the purposes of EU competition law, that law…will apply.”—[Official Report, Health and Social Care Public Bill Committee, 15 March 2011; c. 718.]

I do not have my Hansard reference here, but it was interesting that in a reply to Lord Beecham or Jeremy Beecham, I am not sure how one refers to them—

Mr Burns: The noble Lord, Lord Beecham.

Liz Kendall: Lord Beecham asked a question about whether social enterprises would be counted as undertakings and the relevant Minister from—

Mr Burns: The other place.

Liz Kendall: the other place—said that they would indeed be counted as undertakings. So this is not just about what happens to NHS trusts, it is about how social enterprises in the voluntary sector will be treated, too.

Nick de Bois (Enfield North) (Con): I am grateful to the hon. Lady for giving way. She is generous with her time as ever.

I would like to put this list of hypothetical concerns into some context. It is worth bearing it in mind that we are talking about £100 billion of taxpayers’ money. That will above all else be spent equally to provide high-quality health care with free access for all. Is it not right that this should not be under a monopoly and that we should not be frightened by the prospect of what the hon. Lady is saying? Even though I do not agree with everything she is saying, there has to be some value judgment.

Liz Kendall: I sought to achieve in whatever role I had in life before I came here the very best value for taxpayers’ money. I believe that within the national health service that should be a matter of policy decision based on evidence rather than one of competition law, Monitor or the courts. I will come on to that point in a moment to explain that in more detail.

The Minister has already said that providers will become undertakings and subject to competition law, including EU competition law. The key issue as well about which there is real concern is whether commissioners will become undertakings. My right hon. Friend the Member for Rother Valley has already pointed to a briefing, which I have mentioned before, that was issued last month by the NHS Confederation and Mills and Reeve—a top 50 UK law firm, according to its website—which is called “An introduction to procurement and competition for GP commissioners.” As I have said before, the briefing was published because people were concerned about what the changes would mean for their future. The briefing states clearly that under current legislation—

“PCTs, in commissioning NHS services, are not undertakings and are not subject to competition law.”
It goes on to state:

“Whether or not competition law actually applies to GP commissioning consortia in the future will, however, depend on their exact form and functions and the precise legislative framework under which they act. Also, competition law is a highly complex area which is constantly developing, with new cases being decided and new guidance being issued all the time. This leads to uncertainty as to its application.”

3.30 pm

Liz Kendall: My hon. Friend raises an important point about the costs that are associated with all this. The uncertainty means that—as the NHS Confederation is doing—people will be employing lawyers to interpret the legislation and what it would mean for their members. Those costs are likely to increase.

Mr Steve Brine (Winchester) (Con): I realise that the Opposition want to present all this as radical revolution, but is it not the case now that when primary care trusts are making commissioning decisions they have to adhere to procurement rules? My primary care trust said to me only this morning that it does exactly that. I realise that yesterday’s Opposition day debate fell rather flat, but it is not greatly helpful to repeat these messages.

Liz Kendall: The hon. Gentleman will know the situation. At the moment, PCTs are not counted in their commissioning function as undertakings. Of course, there has always been debate about the degree to which different laws apply, but I am arguing that the changes in the Bill will make it explicit and will expose commissioning consortia to those challenges and issues. The proposed changes could explicitly clarify that they are subject to the full force of competition law, about which, as the hon. Gentleman knows, there is at the very least a lot of uncertainty at the moment.

Tom Blenkinsop: Irrespective of the interpretation of that legislation on each side of the Committee, the point is that if interpretation is shifting all the time it results in constant litigation. The funding for that comes from the NHS budget.

Liz Kendall: The hon. Gentleman knows the situation. PCTs were exempt, under the designation of part B services, because they performed social functions. Under clause 52, which specifies the general duties of Monitor, it is an economic body that promotes competition. It is as clear as day.

Liz Kendall: There are lawyers present. Although I am not a lawyer, I have been attempting—as we all have—to look through the legislation, and there is uncertainty. I am not making it up out of nowhere; I am raising these questions for the same reason that the NHS Confederation and other organisations are raising them, and I ask the Minister just to stop and look at those concerns. He may disagree with them, but he is not a lawyer. Neither am I. I am a member of Her Majesty’s Opposition rightly questioning what this legislation means.

We have had a lot of debate on the reorganisation of hospital services, such as stroke care or trauma care, and the planning of a system across a regional area. That is currently done by SHAs, but the Government say that it will be done by GP consortia. What would that mean under the legislation? Can the Minister guarantee that commissioners will not be considered as undertakings as a result of these changes?

Returning to a point that I made earlier, I have asked the Minister to publish the legal advice, so that we at least have a better understanding of these different issues. I conclude by urging him to do so, because the most telling part of the briefing from the NHS Confederation is the statement that once the competition regime is in place by 2012—I say this respectfully to the hon. Member for Winchester—it will be very different from the previous regime. The King’s Fund says the same. If it was not different from before, arguably there would be no point in the legislation. The NHS Confederation says that competition will be enforced by Monitor through legislation, rather than by NHS policy. Ultimately, where competition should be applied should be based on evidence and decided on by policy, not by lawyers or Monitor and certainly not in the courts—whether in this land or another.

Karl Turner (Kingston upon Hull East) (Lab): I think I am right in saying that a third of the Bill applies competition law—no less than 85 clauses. Clause 60 outlines the Government’s intention to give Monitor concurrent powers to the Office of Fair Trading, under part 1 of the Competition Act 1998. This is the linchpin of the Government’s plan to privatise our NHS.

Nick de Bois: Will the hon. the Minister give way?

Karl Turner: Not at the moment. Let me make a little progress. The 1998 Act prohibits undertakings from reaching certain agreements, decisions or concerted practices that prevent, restrict or distort competition. Giving Monitor concurrent powers to the OFT opens the gateway to wholesale privatisation. The Government must realise that it will be difficult, at best, to close that door once they have opened it.

The provisions contained in the clause will open the NHS up to legal challenges under UK and EU competition laws. That represents a significant marketisation of the NHS. Once the precedent of competition law has been set, it may be impossible to reverse it. The Bill is forcing the Tory ideological commitment to competition and full-scale free marketisation of the NHS. To be clear, we support competition in the NHS where it benefits patients, but we oppose the ideological drive to introduce markets when it will harm services. The Bill is harmful. Its provisions mean that any GP consortium fondly imagining that it can keep using its well-trusted local hospital will be bitterly disappointed when it finds itself tangled in wasteful and time-consuming legal challenges.

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Karl Turner: My hon. Friend is absolutely right, and my hon. Friend the Member for Leicester West was also right about this. It is not so much about the scope as about the application. It brings in competition law. Why is it necessary to have this massive document if this is simply an evolution of what already exists?

Mr Burns: This has been an interesting debate. We have heard most of it before in previous debates. I suppose it goes to the heart of matters, but I am saddened by this philosophy that if someone repeats something that is not factually correct often enough, it might become a fact.

We heard from the hon. Members for Kingston upon Hull East and for Easington—the hon. Member for Easington is a bit of a neanderthal Labour Member—that there is going to be competition within the NHS. Heaven forbid. I suspect that part of the argument put by the hon. Member for Easington is based on the fact that there is going to be competition within the NHS. There was open competition in the health service before 11 May—

Karl Turner: Will the Minister give way?

Mr Burns: No, I am not giving way yet. Let me develop my point. Competition did not start on 11 May 2010. Before that there was open competition between hospitals in the NHS and in the private and voluntary sectors for all elective operations such as hip replacements, cataracts and other medical procedures. Some 200,000 patients a year choose to have their NHS-funded operations in independent hospitals.

The Chair: Order. Please bear with the rest of us, Mr Turner. We would like to hear what the Minister has to say. You might not, but we do. Could we just give him some time to say it? Save it for after the Committee.

Karl Turner: Sorry, Mr Hancock.

Mr Burns: I am very grateful, Mr Hancock.

For the benefit of the hon. Member for Kingston upon Hull East, because I do not think he heard, I will repeat what I said. If he reflects on it, he might learn something.

There always was, and is, competition within the health service under the previous Government and this Government. I gave examples of elective treatment in hospitals and the number of patients who opt under NHS rules to have NHS-funded treatment in private hospitals. There have been major procurements to improve primary care services that involved open competition and brought in new providers.

The next thing that a range of Opposition Members laid into was the question of competition, despite the fact that it was going on under the previous Labour Government.

The Chair: Please, Mr Barron, don’t you start.

Mr Burns: Let me just explain something. If competition is so dreadful, do Labour Members still agree—I know that there has been a regime change—with the right hon. Member for Kirkcaldy and Cowdenbeath (Mr Brown), if they remember who he is? For those who cannot remember, he was the previous Prime Minister and their right hon. Friend. In 2007, after he became Prime Minister, he said to the Liaison Committee:

“We have been asking in people from the private sector to review what we can do to give them a better chance to compete for contracts”.

That competing is competition. If it is all right for the right hon. Member for Kirkcaldy and Cowdenbeath, I am surprised it is not all right for the Labour Members here, particularly the hon. Member for Easington, who I imagine is more of that wing of the Labour party than the hon. Member for Leicester West. I do not know about the hon. Member for Easington. He must be a bit torn between the competing former Prime Ministers and their philosophies.

It is rather extraordinary that Opposition Members are so against this whole concept. It helps to improve patient care and improve quality, which inevitably leads to improved outcomes.

I want to keep this rather brief, because, as I have said, we have been around the houses on this issue in the past month or so. I want to say—so that Opposition Members fully understand—that the clause gives Monitor concurrent powers with the OFT—[Interruption.] Hon. Members say that they know that. Having listened to them for the last hour, I have to say I am surprised that they know anything, given some of the things they have come out with.

3.45 pm

Clause 60 gives Monitor concurrent powers with the OFT in relation to the provision of health care services, under part 1 of the Competition Act 1998. Most sectoral regulators have these concurrent powers with the OFT. The Bill does not introduce the Competition Act to the provision of health care services for the first time. Competition law has always applied where providers are performing an economic function.

Tom Blenkinsop indicated dissent.

Mr Burns: The hon. Member for Middlesbrough and somewhere—[Laughter.] The hon. Member for Middlesbrough South and East Cleveland nods his head in disagreement, but I have to tell him that facts are facts, and nodding his head in disagreement will not alter that.

Liz Kendall: Will the Minister give way?

Mr Burns: No. I am going to develop my argument. We have heard so much from the hon. Lady, and been around in circles, so it is my turn now.

The Chair: Not to go around in circles.

Mr Burns: Not to go around in circles, and certainly not at such length, because I get the impression that most of the Committee would actually like to make some progress.

Concurrent powers would enable Monitor to investigate where it had reasonable grounds to suspect that health service providers had colluded in a way that prevented, restricted or distorted competition, against the interests of patients. I cannot see what is wrong with that, and if
Mr Burns: Partly by experience in other fields of competition law, and through studying and considering the implications of the policy. We do not anticipate the degree of problems that the right hon. Gentleman speculates might arise. We do not believe that it will be at that level.

I do not want to go round in circles. Right hon. and hon. Members have to accept that, if they reflect in the cold light of day, neither this clause nor the clauses that follow in this part of the Bill have anything whatever to do with privatising the health service.

Derek Twigg: Will the Minister give way?

Mr Burns: I will give way to the hon. Gentleman, but this is for the last time.

Derek Twigg: The Minister has not answered the point that my right hon. Friend the Member for Rother Valley made. Returning to my point of order this morning, I remind the Minister that he 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.]

Does he stand by that?

Mr Burns: We dealt with this at the beginning of the Committee this morning, Mr Hancock, and you might like to tell the hon. Gentleman, for whom I have considerable respect, that he asks the questions in his way and I will answer them in mine. I do not need him to sit there telling me how I am going to answer the question. I did not tell him how to pose the question. We dealt with this issue this morning, so once again we are going round in circles, but I will answer the question.

The Secretary of State and I are in agreement. Both our comments are compatible and correct. I said then and I say now that the Bill itself does not introduce any new competition law or extend the applicability of current UK or EU competition legislation. At present, the OFT enforces competition law in most sectors. Under the Bill, Monitor will have the OFT’s existing powers to enforce, where appropriate, competition law in health services. It will do only what the OFT can and I say now that the Bill itself does not introduce any competition law, and through studying and considering the implications of the policy. We do not anticipate the degree of problems that the right hon. Gentleman speculates might arise. We do not believe that it will be at that level.

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

The Committee divided: Ayes 12, Noes 9.

Division No. 56]

AYES

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

James, Margot
Lefroy, Jeremy
Morgan, Nicky
Pouler, Dr Daniel
Soubry, Anna
Sturdy, Julian

NOES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom

Kendall, Liz
Morris, Grahame M. (Easington)
Thornberry, Emily
David Bennett mentioned in one of his recent articles market to which Monitor could refer, or might Monitor—as special cancer services. Would that be considered as a treatment for people who have pancreas problems and such things as specialist renal services, kidney treatment, under the specialised commissioning list. It includes whole list of services that is currently commissioned nationally, only a few weeks ago, but it feels like many more. A services. I think that the Minister very helpfully clarified commissioning board will be commissioning national a national market for services? We know that the NHS in? Would Monitor be able to refer what might be called commissioning board will be commissioning national a national market for services? We know that the NHS in? Would Monitor be able to refer what might be called

The intention is to take the business to about clause 68, which could take some time. Would a 10-minute break be agreeable? Are we in agreement? Does that suit your purposes, Mr Burns? I suspend the Committee. We will resume at 10 past 4.

3.57 pm
Sitting suspended.

4.10 pm
On resuming—

Clause 61
Functions under Part 4 of the Enterprise Act 2002

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

Liz Kendall: I shall attempt to keep my comments brief. As hon. Members know, clause 61 gives Monitor functions that the Office of Fair Trading has under part 4 of the Enterprise Act 2002 in respect of health services in England. Essentially, it will allow Monitor to make market references to the Competition Commission if it has reasonable grounds to suspect that any features of a market would prevent, restrict or distort competition. I have two points to make on that.

First, what is a market in that regard? Does such a market cover a local geographical area? I hope that the Minister will be able to explain what that would cover. Could Monitor say that it requires a whole local area as a market that it does not think there is enough competition in? Would Monitor be able to refer what might be called a national market for services? We know that the NHS commissioning board will be commissioning national services. I think that the Minister very helpfully clarified that when we had the debate on it. That was probably only a few weeks ago, but it feels like many more. A whole list of services is currently commissioned nationally, under the specialised commissioning list. It includes such things as specialist renal services, kidney treatment, treatment for people who have pancreas problems and special cancer services. Would that be considered as a market to which Monitor could refer, or might Monitor—as David Bennett mentioned in one of his recent articles for either The Times or the Financial Times—take diabetes care and say that there was not enough competition in that system, and so on? What is the market and will it be able to cover those different areas?

My second point relates to a more practical question. Hon. Members will be aware that, although the Bill gives Monitor powers that the OFT has, including the ability to refer to the Competition Commission, the Government announced in October last year that the OFT and the Competition Commission would merge. One new competition body will investigate mergers, dominance and cartels. Another body will then take on the OFT’s enforcement and consumer functions. The Government are asking us, in the Bill, to agree to give Monitor functions and powers to two organisations that will actually be abolished and merged into two new bodies, when we do not know what the functions and powers of those two bodies will be. When will we find out what those two new bodies will be—when the OFT and the Competition Commission merge? According to the Department for Business, Innovation and Skills, the different functions are being looked at to decide whether to change them in any way. Will those two new bodies have stronger functions and different functions? How can we agree to a Bill that proposes giving functions to bodies that are going to merge? I would appreciate clarity on that point.

Mr Burns: Like the hon. Lady, I shall be relatively brief. The clause gives Monitor powers to make market references to the Competition Commission if it has reasonable grounds to suspect that features of the market restrict, prevent or distort competition. That could happen, for example, if a number of providers introduced systems that made it difficult for patients to choose providers. Alternative providers would be unable to move between them, or for potential new providers to offer services to patients. In such cases, the Competition Commission would investigate, and if it found an adverse effect on competition, it would determine remedies to address that. Monitor would undertake that function concurrently with the OFT, and the Bill requires those bodies to consult each other when first exercising that function, and not to make the reference if the other body has already done so.

Like clause 60, clause 61 does not create powers that do not already exist. It simply provides for powers currently resting with the OFT to be exercised by Monitor instead. We want to create a single regulator for the health care sector, to provide clarity and a single focus of expertise.

The hon. Lady also asked about what “a market” would cover. That would cover a national market for specialised services—for example, a regional market for elective hospital care, or a more local market for long-term conditions. It would be up to Monitor to define those conditions. I hope that the hon. Lady finds that helpful.

Liz Kendall: Will the Minister respond to my questions about the merger of the OFT and the Competition Commission? When will that merger take place and are the Government considering new powers for those bodies? I assume that Monitor will take that on. It is an important point.

Mr Burns: I have to advise the hon. Lady that that is not an issue. Any necessary changes will be made in future legislation.

Liz Kendall: Asking us to give Monitor new powers over a body and then having to come back to that to with new legislation is confusing to say the least.

The Chair: That is clearly understood by those of us who heard you say it.

Mr Burns: I think that the hon. Lady has misunderstood, but so that there is no misunderstanding on her part, I will write to her and the rest of the Committee.
Evidence suggests that director disqualification, though rarely pursued under the Competition Act 1998, provides an effective deterrent to anti-competitive behaviour. It is vital for Monitor to have a range of enforcement powers to address anti-competitive behaviour by providers, so that it can protect the interests of patients and taxpayers. The power provides a very strong sanction and would therefore be used to address only the most serious breaches. I understand that the Office of Fair Trading has used it only once.

The enforcement powers set out in the Bill are the same set available to the Office of Fair Trading and other sectoral regulators. Indeed, the OFT could currently apply to the courts for the disqualification of a director of a provider of health care services, if it had breached competition law. The Bill does not change the sanctions that can apply to providers, so the hon. Lady was right to anticipate what I would say on that point.

The hon. Lady asked to whom the provision applies. It applies to directors of companies and those in equivalent positions, such as senior staff in NHS providers who perform a director-like role. She also asked from where the power to disqualify directors comes. It does not come from Monitor; it cannot disqualify. Only a court can disqualify a person, and the relevant powers relate to anti-competitive behaviour by providers, so the hon. Lady was right to anticipate what I would say on that point.

Liz Kendall: Can I clarify that? The provision will not apply to GP commissioning consortia. I have already raised the fact that there is some confusion about whether they will become undertakings. Will the Minister please clarify?

Mr Burns: The clarification is this: the provision will not apply to consortia when commissioning NHS services.

Liz Kendall: For clarification, I did not ask where the powers come from; I am clear on that. I specifically asked who would be considered directors. The final question I asked, to which I hope the Minister will now reply, is: what will the implications be of disqualifying directors? Could the provision apply to a whole board? I know that the Minister said that the OFT has never used the power—

Mr Burns: Once.

Liz Kendall: It did so once; sorry. Would there need to be a legal requirement, and could it apply to the whole board?

Mr Burns: I can answer both points. The answer is no, the people to whom she referred cannot be fined; there would be a disqualification from the position. Unless I misheard her, the hon. Lady also asked for the definition of directors within the providers. The definition is a member of senior staff in an NHS provider who is performing a director-like role.

Liz Kendall: I thank the Minister for his answer. I beg to move the amendment.

The Chair: That is good to know.
Mr Burns: I beg to move amendment 498, in clause 63, page 69, line 42, at end insert—

‘(ba) do not act in a manner that would (or would be likely to) prevent, restrict or distort competition in the provision of health care services for those purposes.’.

The Chair: With this it will be convenient to discuss the following: Government amendment 499.

Amendment 492, in clause 63, page 70, leave out line 3.

Government amendments 500 and 501.

Mr Burns: I will be brief. I will speak to Government amendments 498 to 501, but I certainly will not speak to amendment 492.

The Bill states that Monitor’s overriding duty will be to protect and promote patients’ interests. The purpose of the regulations mentioned in clause 63 is to ensure that commissioning processes enable services to be delivered by the best providers; that any conflicts of interest between commissioner and provider functions are appropriately managed; and that choice for patients is promoted on the principle “no decision about me without me.”

The Government are clear that the use of competition in the NHS should be a means of driving up the quality, responsiveness and efficiency of services for the benefit of patients. In future, patients will have more control over their care and will be able to choose from any provider that meets NHS standards and prices. With money following the patient and providers having greater freedoms to respond to patients’ needs, we expect the best providers to thrive and pressure to be put on those providing poorer-quality or unresponsive services to improve.

Competition is not an end in itself. Amendments 498 and 499 clarify our intentions and reduce any potential for misunderstanding by narrowing the scope of regulation-making powers to remove the scope for regulations to include requirements on commissioners to promote competition. We are replacing that with strong and clear provision for regulations to include prohibitions on anti-competitive conduct.

The amendments remove any doubt about whether commissioners could be asked to promote competition for competition’s sake. The sort of anti-competitive conduct that we want to prohibit would include behaviours such as: commissioners and providers agreeing to prevent the entry of a new provider with a potentially higher-quality service; collusion to fix prices; and agreements between commissioners and providers to exclude existing providers from being offered to patients under patient choice.

Mr Simon Burns: I think I can reassure my hon. Friend, because that is the case. Having clarified the scope of Monitor’s powers, I urge the Committee to accept my amendments.
Opposition amendment 492 would remove the express provision that regulations under clause 63 could include requirements relating to competitive tendering. Our intention is that effective regulation should provide a mechanism for ensuring good procurement practice by commissioners, including in their use of tendering. That is important because the use of procurement in tendering has already been well established in the NHS, including under the previous Government. Rules on tendering are already set out in guidance to primary care trusts on procurement that was introduced by the previous Administration.

The regulations would ensure that requirements on commissioners to adhere to good procurement practices, including in the use of tendering, are clear and enforceable. However, it would be for the commissioners to determine how best to make use of procurement to drive improvements for patients. Our aim is simply to ensure that contracts for NHS services are awarded to the best provider, or providers, and that patients have greater choice and control of their area. It is in the best interests of patients and the taxpayer for the scope of the procurement regulations under clause 63 to include requirements relating to tendering. For that reason, I urge my hon. Friends not to support amendment 492 if the Opposition decide to put it to a Division.

Liz Kendall: Let us be clear about what amendment 492 tries to do: it deletes subsection (3). Under the clause, regulations can be introduced that would allow the Secretary of State to require both the national commissioning board and local commissioning consortia to do certain things, one of which, under subsection 3(a), which we are trying to delete, is to require them to put services out to competitive tender. In other words, the provision allows the Secretary of State to say to the NHS commissioning board and local commissioning consortia, “This is what you must put out to tender.” If Government Members think that is about decentralising power and control, I find that quite astonishing. The provision allows the Secretary of State to direct the national board and local commissioning consortia to put services out to tender. I do not think that that is the right approach, which is why I am pressing the amendment to a Division.

Amendment 498 agreed to.

Amendments made: 499, in clause 63, page 69, line 43, leave out paragraph (c).

Amendment 500, in clause 64, page 70, line 13, at end insert—

‘(aa) a power to investigate on its own initiative whether the National Health Service Commissioning Board or a commissioning consortium has failed to comply with a requirement imposed by virtue of section 63(1)(ba);’.

Amendment 501, in clause 64, page 70, line 16, after ‘(a)’ insert ‘or (aa)’.

Amendment 380, in clause 63, page 69, line 45, leave out ‘Subsection (1) applies’ and insert ‘Requirements imposed by regulations under this section apply’.

Amendment proposed: 492, in clause 63, page 70, leave out line 3.—(Liz Kendall.)

Question put, That the amendment be made.
The Committee divided: Ayes 9, Noes 11.

Division No. 59]

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

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

Question accordingly negatived.

Mr Burns: The clause permits the Secretary of State to regulate the procurement practices of the NHS commissioning board and commissioning consortia, to ensure that they adhere to good practice in procurement, protect and promote patient choice, and that they do not act in a manner that would—or would be likely to—prevent, restrict or distort competition in the provision of health care services for those purposes. Such regulations may include requirements to manage the commissioners' conflicts of interest between their interests in commissioning services and their interests in providing them. For example, some GPs might be in a position to provide the services that they commission through their commissioning consortium. While they might be the best provider for a particular patient, we want to ensure that patients are given the choice of provider, and that alternative providers are given a fair chance to provide the service.

Clause 63 also states that regulations may include requirements relating to competitive tendering of clinical services. Where competitive tendering takes place, we want to ensure that bad procurement practice, such as excluding bidders unfairly, could be prevented. Our aim is to create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider, wherever appropriate. However, competitive tendering will continue to be required for certain services, such as when patients have complex and enduring needs that require a range of skills and resources. The clause therefore ensures that commissioners use best procurement practice, protect and promote patient choice, and promote competition in the interests of patients. That will be key to driving up standards, and the clause provides a mechanism for ensuring that it happens.
I also propose to introduce, via new clause 7 and new schedule 2, a power to allow Monitor to accept undertakings—that is, commitments—from commissioners if they have breached regulations under clause 63. Monitor could accept those undertakings in lieu of issuing a direction or of declaring an arrangement ineffective. The 2006 report by Richard Macrory, “Regulatory Justice: Making Sanctions Effective”, stated that such undertakings represent a powerful alternative to traditional coercive, regulatory enforcement action, and have the potential to impose fit-for-purpose sanctions that are more satisfying for both the offender and the victims of non-compliance. The Bill already allows for Monitor to accept undertakings from providers to remedy non-compliance with licence conditions. The amendment provides for a similar power in respect of commissioners and non-compliance with regulations made under clause 63.

Finally, new clause 8 would place Monitor under a duty to set out how it would apply regulations made under clause 63 to commissioners, by publishing guidance. It would require Monitor to consult the NHS commissioning board in doing that, and to seek approval for the guidance from the Secretary of State. The duty would ensure that commissioners are clear on the rules and the behaviour expected of them. I urge the Committee to accept clause 63 and to accept, in due course, the new clauses and new schedule.

Liz Kendall: I want to try to put this in layman’s terms. The provisions mean that not only can the new commissioning consortia—there will be four in my area—be referred by Monitor for behaving anti-competitively or for not putting services out to tender, but that they can be referred by the NHS commissioning board as well. Is that not Government and policy by quangos, ordering around the different consortia?

The Government’s intention in seeking delegated power to make regulations under clause 63 is to establish clear requirements on commissioners that would be binding and enforceable. To remove the ability for those requirements to be enforced would be irresponsible. Monitor needs credible sanctions to deter the types of behaviour that would be bad for patients and taxpayers. I recognise that the majority of GP commissioning consortia and the NHS commissioning board will always seek to do their best for patients. Others may find themselves on the wrong side of the rules, but will respond to a soft approach by Monitor and these powers do not preclude their best for patients. Others may find themselves on the wrong side of the rules, but will respond to a soft approach by Monitor and these powers do not preclude the type of “ineffective” behaviour that Monitor would be bad for patients and taxpayers. I recognise that.

The Chair: With this, it will be convenient to discuss Government amendments 502 and 503.

Liz Kendall: This is an important matter, but I will be brief. Clause 64 gives various powers to Monitor, or it allows for “regulations”—in other words, the Secretary of State—to confer powers on Monitor. Let us be clear that there will be no more proper discussion in Parliament. Clause 64(3) says: “Regulations under section 63 may confer on Monitor—(a) a power to declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective”. Essentially, clause 64(3) allows Monitor to say that a service provided for the NHS is “ineffective”. There are so many questions that one could ask about that, from very simple and immediate questions—for example, how will Monitor determine what is “ineffective”?—to the more fundamental question, “Why on earth should it be up to Monitor to decide to declare an NHS service ineffective?” For that reason, we have tabled the amendment and we are seeking to delete the remainder of the clause, because it should not be up to Monitor to decide that.

Mr Burns: I shall be equally brief. If amendment 493 is pressed to a Division, I will advise my hon. Friends not to be persuaded by the hon. Lady’s argument.

The Government’s intention in seeking delegated power to make regulations under clause 63 is to establish clear requirements on commissioners that would be binding and enforceable. To remove the ability for those requirements to be enforced would be irresponsible. Monitor needs credible sanctions to deter the types of behaviour that would be bad for patients and taxpayers. I recognise that the majority of GP commissioning consortia and the NHS commissioning board will always seek to do their best for patients. Others may find themselves on the wrong side of the rules, but will respond to a soft approach by Monitor and these powers do not preclude Monitor from adopting a soft approach. However, we need to ensure that there are powers in the system to prevent the most damaging behaviour, such as referring patients inappropriately to services that the commissioner has a direct vested interest in. That type of action would result in poor outcomes for patients and poor value for money. We cannot allow the regulations to be ignored and we cannot allow that sort of behaviour to continue unchallenged.

Earlier in our discussions, the Government tabled an amendment that required Monitor to publish guidance, with approval from the Secretary of State, that sets out how it would apply its enforcement powers to breaches by commissioning consortia and the NHS commissioning board. Without enforcement powers, Monitor would be in the same toothless position as the Co-operation and Competition Panel, which the previous Administration established. That body can make investigations and produce reports, but any actions that it recommends are subject to decisions by the Secretary of State. To my mind, that situation is completely inconsistent with having a transparent and independent economic regulator. Therefore I strongly resist amendment 493.

John Pugh: The example that the Minister gives of the type of “ineffective” behaviour that Monitor would seek to intervene on appears to be an example of clearly
in appropriate behaviour, almost improper behaviour, where there is a conflict of interests. Can he briefly say what else is considered to be “ineffective” apart from such an example, because I have to say that that example is not very illuminating?

Mr Burns: I might be able to help the hon. Gentleman by putting on the record exactly what “ineffective” means. It means that the arrangement, in other words the contract, is void. It does not mean that the service is “ineffective”. I hope that that helps the hon. Gentleman.

With the extension of patient choice, however, the need for tendering would diminish in any event. Moreover, the remaining powers for Monitor to set aside a contract where there has been a serious breach of the regulations and to direct the commissioner to put in place measures to prevent or mitigate further breaches should provide sufficient of a deterrent effect. Powers for Monitor to go further and direct the commissioner to put services out to tender would be unnecessary. It is for these reasons that I urge the Committee to accept Government amendments 502 and 503, and to oppose amendment 493.

Liz Kendall: I will make my last comment of the day. I do not like hyperbole, but I think that we are developing a Kafkaesque nightmare of regulation and bureaucracy that is completely unnecessary. The Government may want to see more competition and more diversity, but they do not have to set up all these powers. It is extremely confusing and extremely bureaucratic.

The Chair: A rather confusing situation has arisen. We have to vote again on Government amendments 500 and 501, which were earlier voted for unopposed, because I was a bit presumptuous. I should have waited until after the debate on amendment 493, for reasons that I obviously do not understand.

Derek Twigg: On a point of order, Mr Hancock. You say that you are going to deal with Government amendments 500 and 501, but we have already voted on them.

The Chair: I know, but the Clerk has told me that Government amendments 500 and 501 were grouped with Government amendment 498 to clause 63, but they are amendments to this clause. They should have been called formally after clause 63 stand part. If we call them formally now, we can then call amendment 493. We can take the amendments together if that is the will of the Committee—

Derek Twigg: On a point of order, Mr Hancock. I am trying to get this right. We voted against the clause that had the amendments to it. We have already voted against that clause.

The Chair: The problem is the archaic way—no, it is not archaic—or rather the way in which the amendments are tabled. It is like voting at the end on things that have been discussed earlier. It is the same situation. As no one opposed the amendments, I again move the amendments formally.

Amendments made: 500, in clause 64, page 70, line 13, at end insert—

‘(aa) a power to investigate on its own initiative whether the National Health Service Commissioning Board or a commissioning consortium has failed to comply with a requirement imposed by virtue of section 63(1)(ba);’

Amendment 501, in clause 64, page 70, line 16, after ‘(a)’ insert ‘or (aa)’.—(Mr Simon Burns.)

Question put, That amendment 493 be made.

The Committee divided: Ayes 9, Noes 11.

Division No. 61

AYES

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

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

NOES

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

Lefroy, Jeremy
Morgan, Nicky
Pugh, John
Soubry, Anna
Sturdy, Julian

Question accordingly negatived.

Amendments made: 502, in clause 64, page 70, line 26, leave out paragraph (b).

Amendment 503, in clause 64, page 70, line 29, leave out ‘powers conferred by virtue of subsection (3) are’ and insert ‘power conferred by virtue of subsection (3) is’.—(Mr Simon Burns.)

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

The Committee divided: Ayes 11, Noes 9.

Division No. 62

AYES

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

Lefroy, Jeremy
Morgan, Nicky
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES

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

Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 64, as amended, ordered to stand part of the Bill.
Clause 65

**MERGERS INVOLVING NHS FOUNDATION TRUSTS**

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

Mr Barron: I am not an expert on the Enterprise Act 2002, but the explanatory notes state:

“This clause provides that the merger control regime in Part 3 of the Enterprise Act 2002 would apply to foundation trusts which are not enterprises for the purposes of that regime in relation to mergers between foundation trusts or between NHS foundation trusts and other organisations.”

From the beginning, our debate has been about localism and the fact that commissioners and others can shape local services for patients. Will the Minister explain what the Office of Fair Trading and the Competition Commission have to do with the merging of NHS facilities?

Mr Burns: I have to say to the right hon. Gentleman that that is a very interesting question. I am grateful to him for asking it, and I will not beat about the bush. I will write to him very soon with a full and comprehensive answer.

Mr Barron: We have to decide on this now, Hon. Members are looking bemused, but I am talking about what is in the explanatory notes. Ah, the seventh cavalry has sent something along. Let us hear it.

Mr Burns: I have been very kindly directed along the way—the details were in front of me. I shall now give a full explanation, and I shall do so quickly. The clause enables the merger control regime for enterprises in the UK to be applied to mergers of foundation trusts and mergers between foundation trusts and other businesses. As I continue my explanation, the answer to the right hon. Gentleman’s question will be unveiled.

Under the clause, the OFT could make a reference to the Competition Commission to review foundation trust mergers to test whether they gave rise to a substantial lessening of competition. We want to ensure that mergers of foundation trusts and mergers between foundation trusts and other businesses would go ahead if they did not cause a substantial lessening of competition or if their impact on competition was offset by the benefits that they would create.

We want to prevent or address any adverse effects of mergers that do not create benefits for patients and taxpayers, and which are detrimental to competition and therefore to choice and long-term efficiency.

5 pm

Mr Barron: Does that mean that, on that basis, the OFT and the Competition Commission could not have the power to override what has been agreed locally? Or does it mean that they do have the power to override what has been agreed locally?

Mr Burns: Yes, if there is a substantial lessening of competition.

The Chair: Thank you for that well targeted question, Mr Barron. I am sure that the whole Committee benefited from the Minister’s response.
functions. It would have the ability to request information, but not to undertake raids. It also encourages compliance by permitting the Competition Commission to impose penalties where an organisation does not comply with an information request. The powers are no more and no less than those that the Competition Commission would otherwise have in requiring information to inform market investigations. The recommendations from the reviews will inform the development of policy and the operation of regulatory processes. It is, therefore, vital that the Competition Commission has the powers to collect the information that it requires, for example from commissioning organisations and providers of NHS services.

Liz Kendall: I beg hon. Members’ forgiveness. I said that I was not going to say anything else, but not for the first time or probably the last, I have been inspired to add to the debate. Let us be clear; the provision says that the Competition Commission will carry out a review on whether Monitor is promoting competition enough in the NHS. The Minister has said that it will make informed decisions about that. How will it do so? What health care knowledge does the Competition Commission have?

Mr Burns: Will the hon. Lady give way on a point of correction?

Liz Kendall: The Minister may attempt to correct me if he likes.

Mr Burns: I will attempt to. The review is to see how Monitor is fulfilling its duties in relation to competition, which is not quite what the hon. Lady said.

Liz Kendall: The Competition Commission is going to look at, as the Minister has said, whether Monitor is promoting markets and competition enough in the NHS. What knowledge does the Competition Commission have about health and health care? We have enough problems with Monitor and how democratically accountable it is to people for the decisions it takes that will affect health care. Now we have the Competition Commission reviewing and judging Monitor. We seem to have layer upon layer of decisions that are made by undemocratic, unaccountable bodies that do not know anything about health and health care. It is not about devolving that power and responsibility. Government Members—even the hon. Member for Broxtowe, who it not really allowed to speak because she is a Parliamentary Private Secretary—must question what this is all for. We seem to be imposing layers and layers of bureaucracy. What knowledge or expertise does the Competition Commission have about health?

Jeremy Lefroy: I have a question about the review of competition. I understand why the provision is there, but under clause 52 Monitor has a duty to promote competition “where appropriate.” Will that definition of “where appropriate” be taken into account when the Competition Commission conducts its review? Clearly, the Competition Commission could conduct a review of competition throughout the NHS and decide that in certain areas it does not exist, but that could be because Monitor has decided that competition in those areas is inappropriate.

Paul Burstow: In developing his argument, will the hon. Gentleman set out an example or two? That might help to ensure that he receives the clarification that he seeks.

Jeremy Lefroy: Let us take a basic case, such as the provision of acute services in a district general hospital. It is unlikely that there will be much in the way of competition, because it would be a waste of national resources to have two district general hospitals next to each other under different providers.

Mr Burns: If it would be helpful to the Committee and my hon. Friend, I will answer his question. Monitor’s duty, under clause 52, which he rightly refers to, is to promote competition where appropriate. The Competition Commission would look at how that is being interpreted, but there would be no bias for competition. It would only be where it was appropriate.

Jeremy Lefroy: I am most grateful to the Minister for that clarification. There is no point in us having a massive review of competition in the NHS, and having the Competition Commission decide that it has a remit to look right across the NHS, including areas where it would be inappropriate.

Question put. That the clause stand part of the Bill.
The Committee divided: Ayes 10, Noes 8.

Division No. 64]

AYES

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

NOES

Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz

Question accordingly agreed to.
Clause 66 ordered to stand part of the Bill.

Clause 67

REVIEWS UNDER SECTION 66: CONSIDERATIONS RELEVANT TO PUBLICATION

Mr Burns: I beg to move amendment 381, in clause 67, page 72, line 43, after ‘considers’ insert ‘would or’.

I can be very brief on this minor amendment, which is primarily about drafting. The amendment is required to ensure that the provision in clause 67 is clear in scope and consistent with other provisions in part 3. Its purpose is to ensure that, when publishing a report under clause 66, the Competition Commission must consider excluding information that would, as well as might, significantly harm the legitimate business interests of a person to whom it relates. In a case where it was clear cut that publication would harm legitimate business interests, the commission would have to consider excluding
information from its report. That was always the intention, and the amendment ensures that there will be no doubt. Amendment 381 agreed to.

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

The Committee divided: Ayes 11, Noes 8.

Division No. 65]

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

Lefroy, Jeremy
Morgan, Nicky
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz

Morris, Grahame M. (Easington)
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 67, as amended, ordered to stand part of the Bill.

**Clause 68**

**CO-OPERATION WITH THE OFFICE OF FAIR TRADING**

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

The Committee divided: Ayes 11, Noes 8.

Division No. 66]

AYES
Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
Lefroy, Jeremy
Morgan, Nicky
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 68 ordered to stand part of the Bill.

The Chair: Before I take the motion from the Whip, I should like to say how appreciative I was of Mr Burns’s ability to take his signal from his Whip. It must be the old habits of being a Whip that meant that you were able to do that so effectively.

Ordered, That further consideration be now adjourned.—(Stephen Crabb.)

5.16 pm

Adjourned till Tuesday 22 March at half-past Ten o’clock.